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SOME COMMON OTOLOGICAL PROBLEMS*

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The practicing otologist encounters many problems, great and small, which present much difficulty of solution. To the physician many of these conditions may seem exceedingly trivial and of little or no importance, but to the patient himself they may be most annoying, causing great discomfort and embarrassment, and even destroying his happiness and social contact with his fellow men. It behooves us as otologists to realize the significance of these everyday problems and to do our utmost to solve them as they arise. Too frequently we pass them off by telling the patient there is nothing serious present, that there is but little that can be done about it, and that his trouble will probably clear up shortly of its own accord.

*Chairman's Address, Eye, Ear, Nose and Throat Section, Annual Meeting of the Michigan State Medical Society, Pontiac, Michigan, September 23-24, 1931.

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Or, on the other hand, we may continue to treat a patient indefinitely for some condition which, if only studied more thoroughly and carefully, would reveal the folly of such treatment and permit us to truthfully tell the unfortunate one that no treatment is of any avail and that his ears had best be left entirely alone. This last mentioned factor exists far too commonly in our specialty and

could readily be overcome if only more thought and care were given to making an accurate diagnosis in every case. The question of an accurate diagnosis is the all-important factor in the honest practice of otology.

Given a correct diagnosis, the proper treatment to be administered in any individual case depends to a great extent upon the type of training and the experience of the physician in charge. No one method of handling a case exists in any line of medical practice. But if each patient is carefully studied as to the history, the general physical findings, the localized pathology present, the functional hearing tests, the temperament of the individual patient, and various other factors, we might readily see where certain procedures would prove valuable in some instances, and, on the other hand, the usual methods used in such conditions would be useless in the particular case under observation.

Let us consider a few specific otological problems encountered in our everyday practice. First, as regards the external ear, may be mentioned itching of the canals, caused by eczema or seborrheic dermatitis. This condition is extremely annoying to the patient and frequently is very resistant to treatment. Patients thus affected often dig and scratch their external auditory canals with matches, hair pins, and various other instruments, frequently causing injury to the canal wall, which may result in severe infection, such as furuncles or erysipelas. Furuncles in the canal is another problem which often baffles the otologist. These may be multiple and are frequently bilateral, causing, in some instances, complete occlusion of the lumen, and associated with intense pain. The majority of these inflammations never localize, or present indications for incision, consequently but little relief can be offered these suffering individuals. Various methods may be employed to relieve the pain or hasten the resolution of the lesion, but the condition must, to some extent, run its course. The question as to why a patient should have multiple furuncles in one or both ear canals, and even be subject to recurrent attacks, and never have a single similar lesion elsewhere on the body still remains an unsolved problem and one worthy of our attention.

When it comes to the middle ear there is probably nothing so trying or difficult to

overcome as chronic catarrhal deafness. The slow gradual onset, with definite pathological changes often well advanced even before the patient is conscious of any pending trouble, frequently makes the condition one that is impossible to overcome. These cases should receive the most careful observation and study, for the affliction is amenable to treatment, at least to a certain degree, and these patients with their sensation of fullness in the ears, frequent tinnitus, and progressing deafness, are surely entitled to the best that we have in us.

Careful attention to any associated pathology in the nose and throat, together with thorough and persistent study of the eustachian tube and tympanum is of the greatest importance. These cases try our patience to the utmost and honest, conscientious care must be instituted if we are to expect results. Simple inflations, with massage of the membrana tympani and the careless passing of bougies through the eustachian tube over long periods simply represents a lazy, indifferent attitude toward the welfare of our patients.

The problems presented by chronic suppurative otitis media are too well known to require enumeration in this paper. The all-important point in this instance is to have a definite clean-cut understanding in our own minds as to the indications for a radical mastoid operation. If we can differentiate between those patients requiring radical surgery and those in need of conservative treatment, we will rarely be confronted with any serious difficulty in handling these cases. Many of us are at fault in keeping up prolonged office treatment in those patients who are definitely in need of the radical mastoid operation, while, on the other hand, many needless operations have been performed where sane conservative treatment has been plainly indicated. One of the annoying problems met with in radical mastoid surgery is the inability to get a dry ear in all cases, due to incomplete closure of the eustachian tube. While this is not of serious import, yet it is most distressing to the patient as well as to the surgeon.

An extremely difficult situation to overcome is that of chronic otitis media with a long standing mucus discharge. This may be slight in amount but is more or less constant, always aggravated by an acute infection in the nose and throat and is usually associated with some loss in hearing. The

perforation is always central in type and may be quite large, involving one-half to two-thirds of the membrana tympani. The usual methods of treatment may cause a cessation of the drainage for a time only to have it suddenly recur. These patients are always much concerned about the outcome of the situation and, especially if they are a child or young person, there is great fear and anxiety about the possibility of going through life with a discharging ear. No definite relief can be offered them by surgery of the mastoid, so it becomes our duty to exhaust every possible means at our disposal to clear up the condition.

Probably the most baffling condition with which the otologist has to deal is that of otosclerosis. These poor unfortunate people have usually been here, there and everywhere in quest of relief, and have often had many mutilating operations performed on the nose and throat. Our duty is to make an accurate diagnosis, for if the condition is one of otosclerosis no further local treatment is indicated. The patient should be warned against having long series of inflations or other treatment and be advised to leave the ears absolutely alone, unless, however, there is present some associated pathology which may be amenable to treatment. It is difficult to tell these people that there is no hope for improvement, but if tact is used and we study carefully the psychology of the patient, we can usually gain their confidence and they will greatly appreciate our honesty and frankness. Visits later on to quacks and various healers can be avoided to a great extent if we gain the confidence of the patient and ask him to return to us at stated intervals for a complete checkup on his hearing. Much credit is due the American Otological Society for its sincere efforts in attempting to add to our knowledge of this condition, and we earnestly hope that much benefit will come to mankind from their researches.

As regards the internal ear the otologist is often confronted with the problem of nerve irritation or degeneration. A careful study of each case must be made in order to locate, if possible, the source of the infection. The Kahn test should be made on all such cases as a routine procedure and the entire body combed carefully for all possible foci. Not one, but all of these that are found should be eradicated. A careful history as to any acute infectious diseases is

very important. But the otologist's real problem is in those cases of eighth nerve degeneration of undetermined origin. If the condition is of long standing and is not progressive we need not worry even though we do not locate the cause as the damage has long since been done with no possible chance of repair. But if there is an active neuritis present, together with the associated deafness and tinnitus, we are at a complete loss as to treatment if the etiology is not found. These patients will always find someone who will gladly give them prolonged treatment through the eustachian tube and who, for lack of correct diagnosis, either from ignorance or carelessness, will tell the patient they have a very severe catarrhal condition.

Tinnitus aurium, from whatever cause it may come, is one of the most difficult and stubborn conditions to clear up that we experience in our specialty. These patients are greatly annoyed and worried about the symptom, often becoming extremely nervous over the situation, which, in turn, greatly aggravates the tinnitus. In some instances it is absolutely impossible to eradicate the trouble, especially when associated with the heredity type of deafness, severe anemias, or with arteriosclerosis of the labyrinthine vessels. Continuous irritation of the eighth nerve by a focus of infection, especially dental infections, must be constantly kept in mind as an etiological factor. Dental infections seem to have a definite affinity for the eighth nerve and are often the cause of severe tinnitus. In all cases of tinnitus aurium we should exhaust every possible means to eliminate all foci, carefully study the eustachian tube and tympanum, the ossicles, membrana tympani, and even the external auditory canal, as well as the entire body. Weeks and months may elapse before results may be obtained, while in some cases no improvement whatever is noted and we are compelled to simply alleviate the intensity of the symptoms by administering certain medications.

Many other problems might be mentioned but no effort is made to include here every otological condition, but simply to enumerate a few of those which are commonly met with from day to day in our routine office practice. Neither is any attempt made to offer a solution to these problems as in that event each one would constitute subject matter for an individual paper. It can readily be seen, however, that the otologist is con-

fronted with many perplexities, all of which require the most careful thought and study that it is possible for us to give them, and that no matter how insignificant or trivial a complaint may seem to the physician, it is

frequently very annoying and of great importance to the patient. Let us strive to solve these problems and give to our patients and to our specialty the best we have in us.

INDICATIONS FOR CESAREAN SECTION*

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During the fifty years since Säger advocated suturing the uterine muscle, and especially with the improvements in surgical technic of recent years, abdominal cesarean section has become one of the most useful but at the same time possibly the most abused of obstetrical operations. In spite of frequent discussions of the subject, it is stated repeatedly that this abuse is probably due to lack of knowledge or thoughtful consideration of the facts in regard to this type of delivery. Therefore, it may not be amiss to emphasize more or less established points about the operation and at the same time present certain opinions based on the study of the literature and on personal experience in clinic and private practice.

In the first place, although cesarean section may be done at one's convenience, is not technically difficult as compared to other obstetrical procedures, and should give the best fetal results, it is obstetrically speaking a dangerous method of delivery for the mother. Even when done under ideal conditions in the best hospitals the comparatively low surgical mortality of one or two per cent is three to ten times the maternal risk of vaginal delivery. Nor should remote dangers be ignored, for rupture of the uterus with its frequently disastrous consequences occurs in about four per cent of pregnancies subsequent to cesarean section. In the face of such facts, serious consideration should be given to the probable effect of an existing abnormality on the outcome of delivery by vagina before resorting to abdominal section.

Even more grave are the consequences of cesarean section done under unfavorable circumstances; more especially, long after the onset of labor or rupture of the membranes. Holland's figures are a good illustration:

Operation	Maternal mortality %
Before onset of labor.....	1.6
Early in labor.....	1.8
Late in labor.....	10.4
After induction of labor.....	14.0
After attempts at forceps, etc.....	27.0

Before labor or soon after its onset we have to consider chiefly the actual operative mortality, but late in labor the danger of infection practically makes the conservative operation contraindicated. Certainly, we are not justified in subjecting a mother to grave risk for the sake of a child perhaps already injured and subject to the uncertainties of infancy and childhood.

In this connection, mention should be made of types of operation other than the conservative or classical. Cesarean section followed by hysterectomy, even in the presence of frank infection, is not appreciably more dangerous than classical section before the onset of labor. But, naturally its employment must be restricted to instances where the uterus is diseased or in which future childbearing might be sacrificed for those already living. The low cervical technic as developed by Krönig and modified by Beck and DeLee affords a considerable barrier to the spread of infection from the uterus to the peritoneal cavity. This is an advantage worthy of consideration under any conditions when cesarean section is to be done. Several years ago we demonstrated

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occasional infection of the uterine contents under the most unexpected circumstances, and peritonitis following classical cesarean section with supposedly ideal conditions is far from unknown. Its advantage over the classical operation is most striking when done late in labor, and it has been advanced as a safe method of delivery at that time, with the advantage of preservation of the childbearing function. However, its proponents' enthusiasm is not in keeping with their statistics, as these show only a lessened degree of the same old dangers—immediate surgical mortality, infection, and rupture in subsequent pregnancies. Though recognizing and welcoming the superiorities of this technic, I am not convinced that its results justify any great extension of the accepted indications for cesarean section. In this connection, I should like to state that one disadvantage, that is, the frequently mentioned technical difficulty, has not impressed some of us.

A consideration of the indications for cesarean section shows contracted pelvis to be of first importance. At Harper Hospital this indication is given for one-third of all sections. However, it should be stated that markedly contracted pelvis occur rather infrequently in the private patient group—probably in not more than one-half of one per cent. For the three years preceding 1931 we have in our office the measurements of 340 individual obstetrical patients, each patient being considered as one regardless of more than one delivery. There were six with pelvic inlet contractions and the same number with outlet contractions. In only one case was cesarean section necessary because of contracted pelvis. In the case of inlet contractions we are convinced that external pelvimetry gives very little information, that internal measurement is of some value, but that the degree of disproportion between the presenting part and the pelvis should be the criterion in deciding on section. The so-called test of labor is of little use, since there can be no real test without several hours of good pains with the cervix fully dilated and the membranes ruptured—a very dangerous time to deliver by cesarean in case the head fails to descend. In outlet contractions, the posterior sagittal is equally as important as the transverse of the outlet.

In Detroit the next most important indication is pregnancy subsequent to a cesarean

section done for other reason than contracted pelvis. It is true that the properly sutured uterus usually heals by regeneration of muscle fibers, yet we can never be sure that a defect does not exist, especially if the puerperium was febrile and we are not acquainted with the ability of the operator. I have seen a number of women delivered safely by vagina following cesarean section, but on the other hand have seen one ruptured scar and several others that almost certainly would have ruptured in labor. Is it not reasonable, at least where the section was done on a primipara before labor, to substitute the one or two per cent risk of cesarean section for the four per cent chance of ruptured uterus with its high maternal and almost one hundred per cent fetal mortality?

Pelvic tumors preventing engagement of the head make section necessary occasionally. Ovarian cysts are better removed early in pregnancy if possible. Fibroids of the uterus blocking the birth canal may be pulled up out of the pelvis by contractions of the uterus. However, if the tumors themselves offer an indication for laparotomy, cesarean section followed by hysterectomy accomplishes two things and is no more dangerous than hysterectomy later.

There are certain other conditions for which cesarean section is done, sometimes with scant reason. Patients with uncompensated cardiac disease may justifiably be relieved of the physical exertion of labor by abdominal delivery, which should be followed by sterilization. Severe premature separation of the normally implanted placenta may sometimes make section advisable, especially if the child is alive and viable or if the mother's condition is becoming rapidly worse. However, the good results in a series treated expectantly in Dublin should call for careful consideration of each case before operating. Because of the comparatively high fetal mortality in elderly primiparas, there is a growing feeling that a woman in her first pregnancy and nearing the age of menopause should be informed of the risks and be permitted delivery by cesarean section if she so elects. The operation has been, and apparently still is, frequently employed in one condition for which we now know it to be distinctly contraindicated, namely, true eclampsia. For this disease, cesarean section gives worse results than any other treatment except forcible

dilatation of the cervix. On the other hand, in rapidly developing toxemia with eclampsia imminent, this method of delivery gives excellent results, comparatively speaking, for mother and child. It is also used at times in severe nephritic toxemia where sterilization is indicated. Transverse and other abnormal presentations rarely call for section as delivery from below is usually feasible and safer. Cesarean section for disproportion due to excessive size of the fetus, while often a confession of error in judgment, may be the best solution of the difficulty.

I have referred to the advantages of the low cervical technic when cesarean section is necessary late in labor—advantages which have led to its recommendation in cases where labor has come to a standstill due to uterine inertia or rigid cervix. However, a dispassionate study of the published statistics will convince one that there is not yet much reason to extensively replace our older methods of treatment, unsatisfactory as they undoubtedly are. In confirmation of this opinion, it is interesting to note that of the fifty-one cesarean sections done at Harper Hospital in 1930 there were only two performed on such indications.

The role cesarean section should play in the treatment of placenta previa is a much debated point with the preponderance of evidence, to my mind, against its routine use. It does undoubtedly give the best fetal results, and this may well be the deciding point in cases at or near term with the mothers in favorable condition for section. On the other hand, so often these mothers are frankly or potentially infected,—a con-

dition which gives a frightful mortality rate with any type of cesarean except Porro section. Then too, profuse bleeding in many of these patients makes imperative a prompt introduction of the balloon or a Braxton-Hicks version as being the quickest reliable methods of controlling hemorrhage. It is conceivable that the longer delay in preparation for cesarean section might mean death, and also it is to be remembered that incision of the uterus is inevitably associated with further bleeding. I am prepared to admit that cesarean section under ideal conditions should give about as good maternal results as other methods but have a great fear that recent good reports on several such series will be carelessly interpreted to mean that cesarean section is the treatment of choice for all placenta previa cases.

To conclude: Cesarean section offers a rapid and convenient method of delivery with the minimum of risk to the child but has a high maternal mortality as compared to vaginal delivery. The dangers are greatly increased by its employment under unfavorable circumstances. Furthermore, there is a remote but still definite risk should subsequent pregnancy occur. Consequently, the operation should not be regarded as a cure-all for any and every type of obstetrical difficulty, but instead should be resorted to only when its danger is less than that of the abnormal condition. Often, a decision depends on whether or not an existing danger for the child is great enough to justify jeopardizing the mother for its relief. Under these circumstances it is to be remembered that the lives of the two are not of equal social or economic value.

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EFFECTS OF SPINAL ANESTHETICS ON SPINAL CORD AND ITS MEMBRANES

Loyal Davis, Hale Haven, J. H. Givens and John Emmett, Chicago, emphasize the fact that the spinal anesthetic solutions in common use today are hemolytic as well as myelolytic and would seem to act on the myelin of the nerve fibers as they do on the lipoids of the red blood cell membrane, causing its dissolution. After the injection of the spinal anesthetics in most prevalent use today into the spinal dural sacs of dogs, they have observed the following changes: (1) a varying degree of inflammatory reaction in the leptomeninges; (2) passive changes in the ganglion cells of the gray matter of the cord similar to those seen in retrograde or so-called wallerian degeneration; (3) swelling and fragmentation of the axis cylinders; (4) signs of degenerative

changes in the fiber tracts of the cord. The fact that the last three of these changes were not pronounced in the cords of animals which were allowed to live ninety days speaks against their permanent nature. This is also suggested by the incomplete picture of degeneration in the ganglion cells and the cervical and dorsal segments. However, the inflammatory changes in the leptomeninges were so constantly present that they cannot be overlooked. The authors hope to extend their studies to the spinal cords of human beings and to incorporate their results with those clinical observations which have been made in a careful neurologic examination of patients who have been operated on under spinal anesthesia. In many instances neurologic complications have been present for as long as a year after the injection of the spinal anesthetic.—*Journal A. M. A.*

VISCERAL SYPHILIS*

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Syphilis as a cause of disease in the abdomen is not frequently encountered in general practice. In a clinic for patients with syphilis, approximately 3 per cent of the patients will be found to have syphilitic disease in the upper part of the abdomen, and of the great majority of these the liver or stomach will be the organ involved. Syphilis of the pancreas and bowel is a rarity. In this paper I shall consider syphilis of the stomach and liver, because even though they are not common diseases, both offer exceptionally interesting diagnostic and therapeutic problems, and the fact that they frequently afflict the same patient materially adds to the problem of treatment. The diagnosis of gastric or hepatic syphilis frequently has been made at the time of an abdominal exploratory operation, and this no doubt will continue to be the most common means of conclusive diagnosis in the future. This is not said in condemnation of present day diagnostic ability, because such exploratory abdominal procedures often have been justified by demonstration of disease in the liver which could not previously have been suspected, and since the treatment of hepatic syphilis is a problem which entails specialization in the use of the arsphenamines, early recognition of the hepatic disease is of great significance in planning subsequent treatment.

SYPHILIS OF THE STOMACH

Gastric syphilis has been a controversial disease for some time. The debate has centered around the point whether diagnosis is possible unless the *Spirocheta pallida* has been demonstrated in excised tissue from the stomach. The less critical group of disputants believes that a diagnosis of gastric syphilis is justifiable when a demonstrable gastric lesion disappears under antisyphilitic treatment, and when this effect is accompanied by constitutional improvement and the relief of gastric symptoms. It is necessary to emphasize the fact that the term gastric syphilis is applied only to those cases in which demonstrable syphilitic organic disease of the stomach is present; gastric crises and reflex gastric disturbances of patients who have syphilis are not included in the term, nor is the large group of disturbances

of patients, who have syphilis, and, in addition, a simple gastric ulcer or gastric malignant growth. No doubt one of the prominent reasons for the state of confusion that exists in regard to gastric syphilis is due to the fact that malignant or simple gastric ulcers of patients who have syphilis are often misinterpreted as syphilitic lesions. Seven different types of gastric syphilis have been reported: multiple ulcers, single ulcers, single nodules, diffuse gummatous infiltration, nodular ulcerative lesions, chronic interstitial fibrosis, and linitis plastica.

The history in many cases with which I have been concerned was the typical one of gradual but steady decrease in the capacity of the stomach, in spite of the fact that good appetite was maintained. Vomiting usually gave immediate relief, and intervals of relief lasting three to six months were not uncommon. The average age of the patients was thirty-five years, and the duration of the gastric complaint, two years. There was achylia in more than three-fourths of the cases; gastric retention and hemorrhage were not common. Perforation was not encountered in any of the cases.

The suggestion that a gastric lesion may be of syphilitic origin is most frequently made by the roentgenologist. He may make the diagnosis unequivocally, or he may raise the question of possible syphilitic etiology and recommend further examination by the syphilologist. Roentgenologic detection of a gastric filling defect, with firm, rigid borders, absence of peristalsis in the involved region, and a gaping pylorus, taken by themselves are not sufficient evidence on which to base a diagnosis. However, Moore and Aurelius have expressed the belief that a long, central, hourglass deformity, or a diffuse deformity which converts the stomach

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into a narrow tube without shortening it are virtually pathognomonic. The deformity in the majority of cases adjoins the pylorus, is less often of the hourglass type, and is not commonly found to involve the entire stomach.

However, the roentgenologist must bear in mind the secondary features of gastric syphilis, such as disproportionate loss of weight, cachexia without accompanying anemia, persistent vomiting, and postprandial pain relieved by vomiting. The presence of a palpable mass in the epigastrium, associated with a gastric filling defect, does not necessarily warrant a diagnosis of gastric malignancy, for palpable epigastric masses are often present in cases of gastric syphilis.

Clinical signs of syphilis are only slightly more common among patients with gastric syphilis than they are among patients who have both syphilis and gastric carcinoma. In cases of the former group is found indisputable evidence of syphilis in 27 per cent, as compared with 16 per cent in patients of the latter group. Hence, the presence of clinical signs of syphilis, if a patient has a gastric lesion, does not materially help in arriving at a conclusive diagnosis. Similarly, the Wassermann test or flocculation tests are not significant in distinguishing a malignant from a syphilitic gastric lesion. In only 73 per cent of the cases of gastric syphilis I recently reported was the reaction to serologic tests positive.

There can be no controversy over the fact that recognition of the *Spirocheta pallida* in tissue excised from a gastric lesion affords the only means of making a conclusive diagnosis of gastric syphilis. However, experience has taught that it is not possible to demonstrate the *Spirocheta pallida* in every case of gastric syphilis in which tissue is excised for microscopic study, because syphilitic lesions of the stomach may undergo spontaneous involution, leaving residual scarring, just as syphilis of the skin does. In addition, the diagnosis of gastric syphilis is so obvious in certain cases, from the history, roentgenologic appearance, and concomitant clinical features, that exploratory operation and excision of gastric tissue are not warranted.

The most practical and common means of arriving at a diagnosis in this type of case is the therapeutic test. I have found that this is accomplished more readily with the

patient in the hospital and under constant observation, where the intake of food can be measured and the same diet maintained throughout the test. Frequent estimation of the degree of anemia and its variations, besides daily records of weight are made. Intensive application of the arsphenamines, in conjunction with either mercury or bismuth and the iodides, is carried on simultaneously. The response to treatment that patients with recent gummatous gastric infiltration display is little short of miraculous, and within two weeks it is possible for them to leave the hospital and to continue antisyphilitic treatment while ambulant. However, patients with the chronic, interstitial, fibrotic type of lesion respond slightly to antisyphilitic treatment, and it is in this type of case that the therapeutic test loses its value as a diagnostic procedure. Among patients who have both syphilis and gastric carcinoma, nonspecific improvement may be noted following use of the arsphenamines; slight gain in weight, and temporary improvement in gastric distress may be confusing, but since this improvement is usually of short duration, continued observation usually settles the issue. The most difficult phase of the therapeutic test is the decision as to when the medical trial should be stopped and surgical intervention recommended. This is particularly important when the gastric lesion is situated at a point at which surgical excision is possible, and there is the probability that nodal involvement has not taken place. It is my practice to confine the therapeutic test to approximately three weeks, and if there is no gain in weight or strength, no decrease in the anemia, and distress after eating persists, I feel justified in urging exploratory operation; that is, if anything is to be gained by such a procedure. Further roentgenologic studies at this time are of practically no value in helping one to reach a conclusive diagnosis, for in the majority of cases there is no significant decrease in the filling defect and what decrease there is, appears only after several months.

In the cases in which the result is interpreted as a positive therapeutic test, antisyphilitic treatment is continued in courses of six or eight injections of arsphenamine, with mercury or bismuth and iodides, and when the patient's condition permits, further examinations are undertaken to elicit other manifestations of syphilis. The results of

treatment in a group of eighty-one patients with gastric syphilis, observed for from two to nine years, showed that 37 per cent were clinically "cured," 27 per cent were decidedly improved, and of 29 per cent the condition was unchanged. The group in which the condition was unchanged consisted, in the main, of patients with contracted and fibrosed stomachs, who were greatly embarrassed by the small capacity of their stomachs. For such patients, unfortunately, neither continued antisyphilitic treatment nor plastic gastric operation offers relief. In gastric syphilis, early diagnosis and early institution of treatment are rewarded by a high incidence of cure.

SYPHILIS OF THE LIVER

Hepatic syphilis is more common than gastric syphilis, and, in addition, the hepatic complications that appear in the course of, or as a result of treatment for syphilis greatly increase the incidence of hepatic disease among these patients. Involvement of the liver in the course of the early phases of syphilis may be merely transient, or it may lead to acute yellow atrophy and death; on the other hand, hepatic disease appearing in the late stages of syphilis is insidious, slow in its progress, difficult to diagnose, and offers additional therapeutic hazards. Wile has emphasized the features of hepatic dysfunction in association with early syphilis, and Warthin demonstrated the presence of *Spirocheta pallida* in large numbers in the livers of patients who had died of syphilitic acute yellow atrophy. When hepatitis is suspected to be afflicting a patient with acute syphilis, it is advisable to limit the treatment to the use of mercury or bismuth and iodides, until sufficient time has elapsed to determine what course the case is pursuing. Subsequent treatment is dependent on the course the disease has pursued. Hepatic disease of late syphilis appears in the following forms: asymptomatic hepatitis, diffuse hepatitis, gummatous hepatitis, chronic hepatitis, and syphilitic cirrhosis with jaundice (biliary cirrhosis) or with ascites (portal cirrhosis). Asymptomatic hepatitis is important because it frequently is the basis for some of the hepatic complications that appear during treatment. The degree of involvement is too slight to produce clinical signs or symptoms, and as a result the diagnosis is usually made at the time of abdominal operation. Various degrees of dif-

fuse and gummatous hepatitis are to be found among patients with asymptomatic hepatitis, and it is to be remembered as a mild phase in a transient disease, which, however, may be made severe by injudicious treatment.

Gummatous hepatitis rarely occurs alone, but as a rule is accompanied by certain degrees of diffuse hepatitis. Gummatous hepatitis may be in the form of a large, single gumma involving the greater portion of one lobe of the liver, or it may occur as diffuse miliary nodules involving most of the parenchyma. It is unfortunate that neither diagnostic acumen nor existing laboratory aids have reached the point at which it is possible to recognize early syphilitic disease in the liver. In laboratory animals it has been demonstrated that the greater part of the liver must be functionless before significant symptoms are to be recognized. It was because of this fact that in appraising the results of treatment of a group of patients who had syphilitic disease of the liver I limited my survey to the cases in which the diagnosis was made at the time of an abdominal operation. In this group it was found that the results of treatment were less encouraging in the group of patients with diffuse hepatitis and best in those with a single gumma or a few gummas in the liver. It was also observed that in the group of patients who had diffuse hepatitis the results from treatment with arsphenamine were decidedly less favorable than among those for whom mercury and iodides only were prescribed. The intensive use of the arsphenamines in the group of patients who had diffuse hepatitis predisposed to early development of cirrhosis and short expectancy of life. On the other hand, patients with a few gummas in the liver, and but a slight amount of hepatitis, did remarkably well following the use of arsphenamines, mercury, and the iodides. There were several patients with numerous large gummas of the liver who received practically no antisyphilitic treatment, and, except for a large, nodular liver, are well twenty years after operation. These patients probably retained sufficient hepatic tissue, aided by compensation, to maintain their hepatic function. In view of the fact that it is not possible to perform exploratory laparotomy to determine the extent of the diffuse hepatitis in a case of syphilis and disease of the liver, it is recommended that the

antisyphilitic treatment be limited to the use of iodides and mercury or bismuth for approximately six months; at the end of this time observation usually will have permitted more definite conclusions in regard to the status of the liver, and frequently the addition of arsphenamine to the therapeutic program will then be permissible, if the advisability of giving it in small doses is borne in mind.

Cirrhosis of the liver is the result of injury to the liver; syphilis, infections, alcohol, and arsenic are among the causes. Hence, if a patient has syphilis and hepatic cirrhosis, antisyphilitic remedies must be given with great caution, and preferably confined to the use of mercury and iodides administered by mouth. Compensatory hypertrophy is to be encouraged, aided by suitable diuretics and the avoidance of further trauma in the form of hepatotropic drugs. In the late phases of hepatic cirrhosis, little benefit accrues to the liver by treatment for the syphilis.

The opportunity is not available here to consider the hepatic complications encountered in the treatment of syphilis, other than to say that the liver is readily injured not only by the *Spirocheta pallida*, but by arsenic and intercurrent infections as well. Accordingly, hepatic complications should be

anticipated as a late complication of treatment of syphilis.

In summary it should be emphasized that when hepatic syphilis is diagnosed or suspected, treatment should be inaugurated with mercury and iodides, and the dosage increased according to tolerance and the therapeutic response. Frequent observations afforded by the treatment often will permit of crystallization of the impressions that prevailed when treatment was started. Arsphenamine may be used to advantage in cases of the gummatous type, whereas if the patient has extensive diffuse hepatitis, early cirrhosis may develop as a result of its use. Expectancy of life is longest among those with gummatous hepatitis, and it is shortest among those with syphilitic cirrhosis. Functional tests of the liver are of no value if patients have gummatous hepatitis, but in the hepatitis of acute and late syphilis, frequent repetition of the tests over a long period offers an index of the degree of dysfunction.

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SECONDARY ANEMIA*

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It is not possible in a paper of this scope to consider all phases of secondary anemia. My purpose, however, is to point out a few essential points in the diagnosis and to give a general outline of the more significant types of secondary anemia, together with the more accepted methods of treatment.

There are numerous causes of secondary anemia, many of which are obvious, but in the obscure types, identification of the cause may be difficult. In general, obscure forms of secondary anemia may be due to chronic loss of blood, which may be persistent or recurrent and associated with malignant lesions of the gastro-intestinal tract, benign polypoid tumors of the stomach, benign ulcers of the small intestine and cecum, and polyps of the colon. In many instances, slight

bleeding from hemorrhoids has produced marked secondary anemia. Toxic conditions, including acute and chronic infections, frequently cause marked secondary anemia. Parasites, various chemical poisons, primary forms of blood dyscrasia and neoplastic diseases may also be listed as often producing severe anemia. The significance of dietary deficiency cannot be overemphasized. Occa-

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sionally, even when the diet is adequate, degenerative disturbances, or disturbances of metabolism, may prohibit proper assimilation of the more important dietary factors, may liberate substances which neutralize the dietary factors, thus prohibiting normal maturation of the erythrocytes, or degeneration of certain organs may destroy the normal hormone and enzyme secretion, resulting in improper assimilation of active substances.

Of great importance in the investigation of secondary anemia is consideration of the laboratory data. The anemia may be of any grade, from one of extremely mild degree to one of great severity. In general there is reduction in concentration of hemoglobin and in erythrocytes, although the reduction in the latter may be but slight. Practically always the percentage of hemoglobin is reduced more proportionally than the erythrocytes; this results in a low color index and also in a low iron index. The morphologic considerations of secondary anemia are likewise of importance. A great deal of evidence may be obtained as to the regenerative activity of the bone marrow, the content of hemoglobin of individual cells, and as to the presence or absence of toxicity, chronic infection, and primary forms of blood dyscrasia.

THE TWO GENERAL TYPES OF BLOOD PICTURE

In the more obscure forms of secondary anemia, two general types of blood picture will be found. I shall try to describe features of the first of them. It is characterized by rather marked decrease in the percentage of hemoglobin, with the number of erythrocytes remaining practically normal. Regeneration of erythrocytes is normal, as is evidenced by anisocytosis, or variation in the size of erythrocytes, with a tendency toward increase in size, or macrocytosis. A normal degree of regeneration in bone marrow is indicated by polychromatophilia, erythrocytes in which the basophilic spongoplasm has not been entirely replaced by hemoglobin, reticulated erythrocytes, immature erythrocytes in which the basophilic spongoplasm, not yet replaced by hemoglobin, is stained by a vital dye. The reticulated erythrocytes in general also will be found to be normal. In severe cases of this first type there generally is marked evidence of regeneration of blood; normoblasts or nucleated erythrocytes of the definitive series,

and Howell-Jolly bodies, may be present. The characteristic morphologic feature of the blood is the marked hypochromasia of the erythrocytes; the cells have a pale, washed-out appearance. There may also be slight anochromasia or piling of chromatin around peripheral portion of erythrocytes. The leukocytes for the most part do not show change in structure, unless there is an associated infectious process or other condition which may produce toxic changes in the neutrophils and monocytes. Toxic changes are evidenced in the neutrophils by blurring of the chromatin of the nucleus, a tendency toward a shift to the left, which means decrease in the number of lobes and intensification of the granules of the cytoplasm. In the monocytes the nuclear structure is hazy, and has a washed-out appearance; there is a tendency toward indentation of the nucleus and generally more or less vacuolization of the cytoplasm. There may or may not be heavy azurophilic granules in the cytoplasm. This first type of secondary anemia is found chiefly in females, and in some instances a definite cause for it cannot be found. It may be the result of menorrhagia, chronic loss of blood from other causes, chronic infection, dietary deficiency, and so forth; however, it is not necessarily confined to any one of the causes just named, but may be a combination of factors.

In the second type of secondary anemia there is an almost proportionate reduction in the concentration of hemoglobin and in the erythrocyte count, resulting in a color index closely approximating 1. The number of reticulated erythrocytes may be decreased, but in some instances a definite increase in their number is found. The leukocytes as a rule are practically normal unless there is an associated toxic factor, which may or may not be the causative agent of the anemia. Morphologically, the erythrocytes give evidence of only a slight decrease in the amount of hemoglobin, and there is, in most instances, but little evidence of regeneration. Frequently, the evidence of degeneration may be more pronounced than that of regeneration, although, in certain cases, particularly as a result of hemorrhage, the features of degeneration and regeneration are found in about equal proportion.

Although in general most cases of obscure secondary anemia will fall into either the first or second of the types described, so far as the morphologic picture is concerned, yet,

in many cases, varying degrees and combinations of the characteristics of both types are exhibited. Such cases cannot be properly classified.

THE NEED OF EXTENDED SEARCH FOR THE CAUSE

Treatment for secondary anemia should not be instituted without complete study of the patient. The general tendency is to treat anemia with only a superficial search for the underlying cause. Since investigation of secondary anemia frequently entails detailed examination, this is often slighted, and occasionally serious disease may pass unrecognized, particularly if the blood responds to the type of treatment given. It is not necessary that the patient be deprived of therapeutic measures until such a search has been made, for many times the anemia is so severe that treatment is essential. Nevertheless, while the treatment is being carried out, thorough examination for the initial cause and its contributing factors should be conducted. Besides complete roentgenologic examination of the gastro-intestinal tract, emphasis should be placed on examination of stools for occult blood, for frequently bleeding lesions, particularly of the small intestine, can be recognized only by this means. If the stool is positive for blood at the first examination the patient should be given a meat-free diet for several days, following which stools should be examined for at least a week. One negative stool examination is practically of no significance, for frequently bleeding will be of relatively short duration and thus observation over a number of days is essential. If blood is found persistently, abdominal exploration may be advisable, particularly if accompanied by even mild gastro-intestinal symptoms. Many cases in which there has been persistent and chronic loss of blood have proved to be examples of early malignancy or benign bleeding lesions in the gastro-intestinal tract, evidence of which could not be discovered by roentgenography.

TREATMENT

Experimental work, as well as clinical experience over a number of years, indicates the efficacy of iron in the treatment of secondary anemia. Iron is generally found to be of much more value in secondary anemia

when there is a low color index than in the type in which there is equal reduction in hemoglobin and in erythrocytes. Forms of anemia which are due to chronic loss of blood, dietary deficiency, pregnancy, chronic infections, and the so-called chronic chlorosis, or hypochromic anemia are frequently benefited by adequate doses of iron. Iron could not be expected to be of benefit in secondary anemia due to primary changes in bone marrow, in which the bone marrow is aplastic, or in a condition in which destruction of blood far outweighs regenerative activity. The exact form in which iron is prescribed is less important than the fact that it be given in sufficiently large doses and in such a general state that it can be readily assimilated. For this reason it is preferable to use a soluble iron salt. The optimal dose of iron is approximately 1 gm. of metallic iron daily. This amount will be obtained by approximately 90 grains of ferric citrate, 90 grains of ferric ammonium citrate or 35 Blaud's pills daily. It is important that treatment with iron be continued for a few weeks, even after the blood has returned to normal, in order to supply adequate amounts for subsequent use in the synthesis of hemoglobin. In many instances administration of iron will have to be continued indefinitely, particularly in the hypochromic type of secondary anemia. Large doses will produce definite improvement in the blood, whereas smaller doses will give little if any effect. The diarrhea that occasionally is caused by large doses of iron may be prevented, to a large extent, if the iron is taken immediately after meals together with a glass or two of water. However, if this does not afford relief, smaller doses may be given for a time and the dose gradually increased until the maximal amount again is being given. Iron supplements the action of other substances, as has been shown by recent experimental and clinical investigation, and it is generally conceded that the combination of liver and iron is much more effective than either alone. In the past, many of the failures accredited to treatment with iron undoubtedly were due to inadequate dosage.

Whole liver, either raw or cooked, has been proved to be effective in the treatment of secondary anemia. It must be emphasized that liver contains many substances other than the principle which is active in pernicious anemia. It has been shown that

this effect is not due to the iron in the liver but that other materials are present which produce active regeneration of hemoglobin, particularly in anemia due to chronic loss of blood. However, as a rule, whole liver is not as effective as iron salts and certainly is much more difficult to take. It is essential to take the liver over a relatively long period, for it is necessary to provide the substances of which hemoglobin is built before hemoglobin can be synthesized.

Clinical observation on the use of liver extract which contains the principle that is active in the treatment of pernicious anemia has given little evidence of response in secondary anemia. In some instances, good results have been reported from the use of a combination of liver extract and large doses of iron, but in view of the expense of this preparation and the fact that iron salts or even whole liver is much more potent, its use is not recommended.

In the Section on Clinical Hematology of The Mayo Clinic, we have used a preparation of desiccated liver of fetal calves in the treatment of obscure cases of secondary anemia, and have obtained excellent response in anemia, of the hypochromatic type, some cases of which previously had failed to respond to large doses of iron or whole liver. This preparation apparently provides, as does whole liver, substances from which hemoglobin can be built and which can be readily assimilated by the body. Here again it is essential that treatment is carried on for one or two months even after the blood has become normal, and in some instances it has been necessary to continue to use the preparation almost indefinitely.

Arsenic has been used for many years in the treatment of primary and secondary anemia. Judging from recent experimental evidence, it seems that arsenic depresses the production of erythrocytes, and that it is only after cessation of administration of arsenic that there is increased activity of the bone marrow. At present, therefore, there seems to be no adequate justification for its use in secondary anemia.

Copper has been shown to produce increased regeneration of blood of anemic rats, and copper in conjunction with iron has been shown to be effective in anemia of infants. Copper and manganese have been suggested as supplements to iron in the syn-

thesis of hemoglobin in cases of secondary anemia. Clinical investigation thus far has not demonstrated either the efficiency or inefficiency of independent administration of copper and manganese.

Transfusion should be regarded as an emergency measure, or as a preliminary adjunct to the treatment of secondary anemia. In severe cases of chronic anemia, regardless of type, when the number of erythrocytes and the concentration of hemoglobin are low, and morphologic studies reveal inactive regeneration, transfusion undoubtedly is indicated; also, patients who have severe anemia associated with low blood volume will be rapidly benefited by this means. Frequently transfusions have a tendency to slow the response of the blood to other methods of treatment and their use should be restricted to cases of very severe anemia.

The part played by achlorhydria as a causative factor in secondary anemia of hypochromic type has received much consideration in recent literature. It is described as afflicting chiefly women between the ages of thirty and fifty years, and as generally being insidious in onset. Authors do not agree on response to treatment; some find definite improvement from the use of preparations of iron and liver, whereas others report no improvement. In our experience, at the clinic, the same clinical type of anemia which these women have, together with all the same laboratory findings, has been found in the presence of normal or high concentration of gastric acids, and the response to treatment of patients who have achlorhydria has been practically identical to that of patients who do not have achlorhydria. At the present time, further investigation of anemia in the presence of achlorhydria is necessary, and undoubtedly other factors, such as menorrhagia, dietary deficiency, and metabolic disturbances may be shown to play a very important rôle.

Dietary deficiency must receive much consideration as a causative factor in chronic obscure secondary anemia. Careful investigation of the type of food eaten by the patient often will lead to the discovery of a marked inadequacy of certain factors. In a casual history many patients will insist that they eat ample meat, green vegetables, fruits, and that their intake of vitamin is adequate, whereas a detailed history will reveal unbalanced meals and inadequate ali-

mentary essentials. As has been suggested before, dietary deficiency may exist in spite of an adequate and well balanced diet if the bodily processes are unable properly to assimilate the food. On the basis of experimental work, a diet for secondary anemia should contain ample vitamins, vegetables, red muscle meat, liver, kidney and fruits; among the fruits, particularly apricots, peaches, prunes, and the juice of citrus fruits. Experimental work seems to indicate that the green vegetables are of more value for their mineral content than for their chlorophyll nucleus. Such diets, supplemented with large doses of iron, are logical in the treatment of most types of secondary anemia.

SUMMARY

It is essential that a thorough search be made for the causative factor, in a case of secondary anemia, and elimination of this may require extended investigation. Morphologic study of the blood is of value, in that it frequently gives information in regard to the primary cause and in addition supplies information in regard to the condition of the blood-forming organs themselves. An adequate and well balanced diet, large doses of iron together with whole liver, seems to be the best single treatment for most cases. It should be emphasized that each case of secondary anemia requires individual attention and no one type of treatment should be used as a routine.

PERNICIOUS ANEMIA

REPORT OF AN UNUSUAL CASE

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The characteristic features of pernicious anemia are well known and to the man familiar with the disease offer no great diagnostic difficulties. The characteristic blood findings, the absence of free hydrochloric acid in the stomach, the cord changes, and the general appearance of the patient are diagnostic points that quickly suggest the probable diagnosis. However, it is becoming increasingly evident since the advent of specific therapy for pernicious anemia that there are cases being diagnosed as pernicious anemia that in former years would not have been classed as such. The reason for this being that the response to therapy has now become one of the important diagnostic points.

The following case history is presented as an example of the diagnostic difficulties encountered in these cases. The difficulties of diagnosis and the possible errors in therapy in the days previous to 1926 are made very apparent.

CASE REPORT

A business woman, 57 years of age, unmarried, was first examined during October, 1929. She complained of extreme weakness. She stated that this had been noticed since 1922. She had continued to work for about two years but by 1924 she was unable to do any work, due to general weakness. At that time she had no other complaints. At the time of giving up her work five years ago, she was examined by a competent internist and he reports his findings as follows: "The following is a report of our findings made in September, 1924. The patient complained of general weakness of about two years duration. Examination showed a general fullness of the epigastrium with a mass in the upper left quadrant occupying the splenic position. This

also produced a dullness in the left lower chest. The heart was a little enlarged and a little rapid, but no murmurs were present. Knee jerks were brisk. The urine showed transient traces of albumin. The stool analysis was negative, except for three plus mucus. Gastric analysis after an Ewald meal showed 38 degrees of total and 20 degrees of free acidity. She was sent into the hospital for differential diagnosis of the upper left quadrant mass. A barium enema showed a depression of the splenic flexure, but the bowels otherwise were normal. Plain plates of the genito-urinary tract showed the right kidney to be normal. The left kidney was not definitely located. A shadow of soft tissue density was seen partially covering the region of the left kidney and extending high up to the region of the spleen. The spleen, however, was well outlined overlying this other shadow. 'If this is kidney, it is in an unusual position.' A number of phleboliths were present on the left side. X-ray of the chest showed the apices to be clear, but demonstrated rather extensive bronchial and peribronchial infiltrations. A pyelogram made following cystoscopy showed the left kidney enlarged, much ptosed and rotated upon itself. The pelvis was not seen well because of this rotation. Although quite anemic, blood studies were not carried out."

Following this the patient returned home and continued in much the same state of health for the next five years. The only other symptoms noted were a

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very distressing generalized pruritus and areas of subcutaneous hemorrhage, slightly painful, scattered over different parts of the body. These occurred in crops of one or two at a time, gradually turned color and disappeared. These areas were most frequent on the extremities. About 1923 she first noticed a large painless mass occupying a large part of the left side of the abdomen. This persisted with no local symptoms and no appreciable change in size. During the past five years the tongue has frequently been painful for periods of several weeks at a time. The body weight has remained between 97 and 100 pounds during her illness. During the latter half of 1929 she first noted numbness and tingling of the hands and feet, and this has progressed till at the present time she feels quite unsteady on her feet, and at times loses the sense of where her feet are. There is no history of loss of blood, except on one or two occasions there has been a small streak of blood from a hemorrhoid. She has never had any urinary symptoms. The appetite had gradually failed till at the time of examination in October, 1929, she had no desire for food. She never experienced abdominal distress and the bowel movements had always been normal.

Family History.—One sister died with an obscure illness several years ago. She had a very large spleen and also she is said to have had anemia. Any exact details of her illness are not available.

Physical Examination.—The patient appeared to be of about stated age; there was extreme pallor, with a slight icterus of the sclerae. The nutrition was poor, the hair gray, and the patient complained of some generalized itching. The pupils were equal in size, regular in outline, and reacted promptly to light and in accommodation. The teeth had all been removed. The throat was not abnormal. The tongue was not smooth, but the papillae were very small. There was no enlargement of the superficial glands. The thyroid was not felt. A few crackling râles were heard at both lung bases. The heart was not enlarged, regular rhythm, sounds well heard, no murmurs. The blood pressure 133/80. The abdominal wall was on a level with the thoracic cage. A fullness was noted extending down from the left costal margin a handbreadth and a half and reaching almost to the midline of the abdomen. A distinct notch could be felt and the mass did not occupy the flank. The liver was enlarged two inches below the right costal margin with a smooth border and was not tender. Rectal examination revealed a few hemorrhoids externally. Otherwise nothing of importance.

Neurological Examination.—The knee jerks were very sluggish on the right side, absent on the left. Ankle jerks were absent. Sense of position of the legs slightly impaired. A marked impairment of vibratory sense was noted over the long bones of both lower extremities. Sensation to pin-prick normal. No Babinski.

Laboratory Findings.—Blood Kahn negative. The urine, on repeated examination, showed nothing abnormal. Examination of stool showed no evidence of occult blood. Gastric analysis showed an absence of free hydrochloric acid. No blood. Resistance of red cells to hypotonic salt solution. Initial hemolysis .34%. Complete .28%. Normal control—Initial hemolysis .42%. Complete .28%.

Blood Studies.—Hemoglobin .32% (Sahli); R.B.C.'s 1.5 million; W.B.C.'s 24,000. Polymorphonuclear neutrophils 65%; lymphocytes 25%; monocytes 3%; eosinophils 4%; basophils 3%. The platelets appeared normal; red blood cells showed many large oval forms, a few nucleated reds. No myelocytes.

X-ray examination by Dr. H. H. Pool is reported

as follows: "Stereoscopic films of the abdomen and pelvis show normal bone structure of the lumbar spine and pelvis. No calculi are seen. The liver shows apparent moderate hypertrophy, at least it extends below the costal margin further than is normally seen. The lower pole of the right kidney is just at the iliac crest. The left kidney cannot be definitely outlined. We note an elongated kidney-shaped shadow on the left, extending from the region of the diaphragm to below the iliac crest. This is probably an enlarged spleen."

The patient was seen in consultation by Dr. Frederick A. Collier. He stated that the mass in the left upper abdomen was probably spleen.

Treatment.—The patient was started on Lilly's Liver Extract and within one week showed the characteristic response that patients with pernicious anemia exhibit when given liver. The appetite at the end of one week was excellent. By the end of six weeks the hemoglobin was 90% and the red cells four million. The white count remained the same. The study of the stained smear showed no abnormal blood cells. On December 31st, two months after starting treatment, the examination of the blood was checked by Dr. Cyrus C. Sturgis of the Simpson Memorial Institute. He reported the differential blood count as follows:

	Per cent
Polymorphonuclear neutrophils, adult.....	61.5
Polymorphonuclear neutrophils, young.....	20.5
Eosinophils	4.0
Basophils	3.0
Large lymphocytes	5.5
Small lymphocytes	2.0
Monocytes	3.0
Path. lymphocytes	0.5

The platelets are slightly increased. Red blood cells are normal in shape with some inequality in size.

Subsequent Course.—At the time of admission to the hospital it was discovered that the patient had fever, with an average daily temperature of 102. This continued without symptoms while the patient was under observation, but promptly subsided to normal during the first week after starting treatment with liver extract. The appetite rapidly became normal and had remained so up to the present time (July 1, 1931). She did not gain weight, and the general weakness, although noticeably relieved, has remained to a moderate degree up to the present time. The itching of the skin has continued to be very troublesome. At times this prevents sleep. She was seen by Dr. Udo J. Wile, who found no skin condition present. She was given mild X-ray treatment on several different occasions with no improvement. Up to the present time nothing that we have tried has given any relief for this very distressing symptom. The ecchymoses still recur on the arms and legs in patches varying in size from a dime to a silver dollar. They come on abruptly over night with pain and swelling of the part and during the next two weeks gradually disappear.

Examination of the blood at intervals since October, 1929, up to the present time has shown no change, except for a relative polycythemia. In June, 1930, the blood count was as follows: R.B.C.'s 6,690,000; W.B.C.'s 28,500; hemoglobin 89% (Sahli); the smear showed normal white cells and a preponderance of polymorphs. There was nothing in the character of the white blood cells to suggest leukemia. Repeated examinations of the gastric contents show a continual absence of free hydrochloric acid. Neurological examination indicates progressive cord changes as evidenced by symptoms and vibratory sense. The patient has been examined by Dr. Cyrus C. Sturgis and the blood studies have been

checked by his staff at the Simpson Memorial Institute on several different occasions.

DISCUSSION

This case presents many unusual features. The leukocytes of the blood are uniformly reduced in number during a relapse and are usually between 1,000 and 2,000. Counts of 400 to 600 are not unusual. A leukocytosis speaks strongly against pernicious anemia. The usual response to therapy is a mild leukocytosis during the increase in red cells and hemoglobin, with a return to the normal number after the blood has reached its normal level.

The size of the spleen does not vary a great deal in the majority of cases. Sturgis finds the spleen to be barely palpable in not more than 25% of the cases and never increased so that it is larger than can barely be felt with the hand. Collier tells me that in the days when splenectomy was done for pernicious anemia, the spleens were always smaller than normal. In the present case the spleen became very greatly enlarged. It resembled the size of the spleen seen in myelogenous leukemia. Furthermore it is known that this patient had a very large spleen for at least five years before treatment was instituted.

A certain small percentage of patients have some itchiness of the skin, due to the hemolysis of the blood. Also, a certain small percentage have subcutaneous hemorrhage during a severe relapse. Both of these groups lose these symptoms as soon as the blood count returns to normal. In the present instance, both symptoms persist in a very distressing form.

The average patient gains weight after the beginning of treatment at the rate of about one pound per week. The average gain in weight for a large number of cases was 19 pounds in 20 weeks. This patient improved in strength but the weight remained about the same.

All patients with pernicious anemia have an absence of free hydrochloric acid in the stomach. In the present case it is established that there was a normal amount of free hydrochloric acid five years before beginning

treatment, but that since 1929 there has been a constant absence of free acid in the stomach.

SUMMARY

The case report brings out the following points of interest: A severe anemia with a color index of 1.2; a marked leukocytosis; absence of free hydrochloric acid in the stomach; a very large spleen extending down about eight inches below the costal margin; moderately advanced posterolateral sclerosis; large ecchymoses coming in crops in various parts of the body; severe generalized pruritus, without evident dermatological changes. On being given liver extract, prompt return of the red cells and hemoglobin to normal and maintained in that condition for a period of two years; the size of the spleen remaining the same as at the onset of treatment and the leukocytosis remaining constantly between 16,000 and 24,000 during that interval of time. The study of the stained cells shows no abnormal cells in the circulating blood, after taking liver extract or ventriculin.

The pruritus and ecchymoses continue as before. The cord changes are progressive. The appetite is excellent but the patient remains constantly underweight. Furthermore it brings out the interesting observation that this patient is known to have had a very large spleen for at least five years before treatment was instituted. Also, of equal importance is the established fact that this patient had a normal amount of free hydrochloric acid five years before beginning treatment.

CONCLUSIONS

1. Certain atypical cases of severe anemia are now being diagnosed as pernicious anemia, largely on the basis of their response to liver or ventriculin.
2. Such cases of severe anemia have formerly been classed as Banti's disease or other form of splenomegaly with severe anemia.
3. Blood destruction, as evidenced by large ecchymoses, may persist in patients with pernicious anemia, although the blood count is maintained at a high normal level.

THE BIRTH CONTROL MOVEMENT*

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DETROIT

The development of the Birth Control Movement has been a gradual evolution. This problem has been under discussion in one phase or other for many centuries. It has been closely allied to the eugenic movement. For many years its pros and cons were discussed under the heading of "Limiting of Population." This was at first viewed from the standpoint of the human race as a whole, and the welfare of the race and its relation to food supplies was then the chief topic of debate. And we may say that many an outstanding mind has grappled with, and expressed opinions on, this subject. As the human being became more and more individualistic and the personal rights of man came to be recognized, birth control as it affected the individual or small family group became more and more the topic of controversy.

That individual attempts at contraception have been practiced from time immemorial is without doubt. Biblical references are a testimony to this. And one can hardly conceive of human nature being suddenly so completely altered. It is reasonable to believe that the human race has always indulged in sexual acts even though progeny was not always desired.

At various periods there have been men who have philosophized on this subject from the standpoint of the race rather than that of the individual, and in most instances these men were impressed by the rapid increase in population, the increase being out of proportion to the increase of means of sustenance for the human race. The earlier writers were impressed by the poverty and vice (war) resulting from over-population. Also the higher the birth rate the higher was the infant death rate.

The attitudes and ideas held concerning the methods of limitation of population reveal in a way the ethical standards of each period. Plato and Aristotle both saw a great menace in over-population. And to offset this increase, both advised limiting the period of procreation for all men and women. Plato suggested that the proper age for marriage should be twenty years for women and thirty years for men, and that women should bear children for the state up to forty years of age and men should limit their activity in this respect up to fifty-five years of age. If a child was conceived before or after this

period it was "to be considered in the same criminal and profane light" as if "it had been produced without the nuptial ceremonies, and instigated solely by incontinence." After these years of prime manhood and womanhood Plato's scheme allowed a great latitude of freedom between the sexes, but accompanied this permission with strict orders to "prevent any embryo which might come into being from seeing the light."

"Aristotle appears to have realized this necessity of limitation of offspring still more clearly. He proposed the proper age of marriage at thirty-seven years for the men, and eighteen years for the women, which would of course condemn a great number of women to celibacy, as there never could be as many men of thirty-seven as there were women of eighteen." Aristotle believed that even with this scheme there might be too many children and therefore proposed that the number of children allowed to each marriage should be regulated. And to insure this he suggested that in case of pregnancy after a woman had had the allowed number of children, an abortion should be procured before the fetus had life.

To realize how intimately the idea of limitation of population was related to eugenics we need only to refer to Plato's suggestion for improving the quality of the human race. He proposed "that the most excellent of the men be joined in marriage to the most excellent among the women, and that the offspring should be brought up for the state." And the inferior citizens should be matched with the inferior females and that the offspring "should not be allowed to come to light or should be buried in some obscure and unknown place."

Cultured as these people were in some

*Read before the Kent County (Michigan) Medical Society at its regular meeting held May 25, 1932.

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respects, their ethical standard was still crude. The extreme means proposed to limit increase in population may be taken as a measure of their conception of the magnitude of the difficulty.

In 1798 Malthus in England wrote his essay on *Principles of Population*. His argument was entirely of population versus food supply. He believed that population increased by a sort of geometrical ratio. He believed that in every locality there were certain natural checks to the increase of population, and it was from his writings that Darwin probably got his idea of the survival of the fittest. He also recognized the importance of emigration from overpopulated countries. He was of the opinion that all over the world the limit of population would soon be reached and that soon there would be no more unoccupied lands to which the excess of population could emigrate. His conclusion was that increase in population should be checked, and to accomplish this he advocated self-restraint and sex-suppression. One sees how far the ethical standard of the world has changed in that no longer was feticide or infanticide suggested as a check to excessive increase.

Following Malthus we have the writings of men like James Mill, John Stuart Mill, Francis Place, Richard Carlile, and Senator Robert Dale Owen, who later became ambassador to France. These men departed from the Malthusian principle in that they began to advocate definite contraceptive proposals instead of sexual suppression, and in consequence their proposals were referred to as Neo-Malthusian in nature.

In a sense it is not strange that this movement received its first support, not from medical men, but from those philosophically and socially inclined. Medical men were following a more narrow line of thought and were then interested more in problems of individuals than in those involving the race at large. However, when in the evolution of this idea the problem began to be more an individualistic problem, and as preventive medicine was just beginning to develop, physicians did begin to be interested in this problem. Dr. Charles Knowlton of Massachusetts was the first to add a noteworthy contribution when in 1833 he published a pamphlet entitled "*Fruits of Philosophy*." For many years this pamphlet was circulated in this country and in England. In the meantime opposition to the ideas expressed

became so strong that the opponents under the leadership of Anthony Comstock succeeded in establishing legislation in this country which classified and defined birth control literature as obscene literature. To test the validity of a similar law in England, in 1876 the leaders of the free-thought movement, Charles Bradlough and Annie Besant, announced the publication of a new edition of "*Fruits of Philosophy*" and challenged the right of the police to arrest them. Although the defendants were found guilty the verdict was set aside on technical grounds, and the plea for the Neo-Malthusianism had been given such publicity that interest in it grew by leaps and bounds.

As one reviews the older literature on the subject one is constantly impressed by the importance attached to the question of overpopulation in some countries. And there is no doubt that in some countries this problem has been acute. It gave rise to the necessity of countries having colonies to absorb the excess of population. Since expansion meant simply the seizure of additional territory, war was inevitable in obtaining new lands. The most recent illustration of this is the attempt on the part of Japan to obtain additional territory for her subjects.

In the past, war and epidemic diseases have been the greatest checks to overpopulation. The more war is discarded as a means of settling international disputes, the greater will be the increase in the world's population. The great scourges that formerly depopulated certain countries are now being conquered by preventive medicine and hygiene. As infant mortality is lowered and the span of human life is lengthened population will increase.

To view the question impartially, one may ask whether all these evils of overpopulation are as vital today as they appeared to sociologists a century ago. As mentioned before, the worry of overpopulation at that time was mainly concerning the food supply for the increasing human race. Does that worry exist today, and particularly, does it exist in this country? It is probably fair to state that the problem of food supply is not the same throughout the world. Japan is at present the best example of overpopulation in relation to food supply. And in general this is more true of older countries than of those more recently settled. In this country we must admit that at present overpopulation does not worry us as far as food sup-

plies are concerned. Modern methods of transportation of food-stuffs and intensive methods of production of food-stuffs make it possible to feed an enormous population. If there is hunger in this country it is not because of scarcity of food. It is more likely to be a defect in our social-industrial system in that not sufficient employment can be offered so that the masses can earn enough to purchase from the large food stores at hand. In an industrial nation a continued steady industry is essential and we may ask whether this country is over-populated from that standpoint. In a sense we admit we do have a population problem in this country when we pass immigration laws to discourage immigration. There was a time when we welcomed growth of population. But apparently we are beginning to feel that we can no longer absorb the increases resulting from immigration. We may soon awaken to the fact that "unless a way can be found to call a halt to the present growth of population the struggle for life in the industrial countries must be intensified and the standard of living correspondingly reduced, within the lifetime of the younger generation." Fairchild believes that "under-population exists when the population is too small under existing conditions to permit a society to raise its standard of living to the maximum level that might be possible; over-population exists when the population is too great to permit of the maximum standard." Fairchild further states that it is much easier to avoid over-population than it is to correct it, and is inclined to think that in this country our population has increased beyond the line where the standards of living can be maintained, and he thinks it not unlikely that by the end of the century we may be living under conditions of over-crowding such as prevail in China today.

The individualistic and family reasons for control of offspring have gradually assumed more importance. The increasing higher standard of living has made it more and more difficult to raise large families. The right of womanhood to assert itself has been gradually recognized. Women have won the right to enter many new fields of endeavor and their ability to compete with men cannot be questioned. This competition by women in all lines of work is occasionally a matter of choice but more often it is forced by the economic situation. Woman has gradually asserted and won her inde-

pendence, and among other things she is now demanding that motherhood be voluntary, and she asserts the right to control her own sex life. If motherhood can be controlled so as to fit in with her manner of living she demands the right to do so. Woman has been the patient bearer of heavy maternal burdens for generations, but she now demands the right to regulate to some extent the weight of this burden.

We may here ask parenthetically as to the cause of this apparently new attitude. Let us remember that birth control from the individual standpoint is not new. It is probably as old as the human race. Why, then, all this discussion about it? We might say that this is simply the way the modern age approaches all questions. The former secrecy and hypocrisy is replaced by frankness and candor. The modern age faces the question as it is, faces the facts in the open, and is frank about discussing these problems. This is reflected in all of our activities, as demonstrated by our literature, drama, and painting. The ideas are not new, but the frankness with which these things are discussed gives the impression that a huge change has taken place. Whereas formerly birth control was a secret with the individual, now it has become a topic for public discussion.

For a long time the medical profession has recognized that some women can bear children only with definite risk of health and life. The list of diseased conditions that are aggravated by pregnancy need not be mentioned here. We all know that the occurrence of a pregnancy in the presence of some diseases may mean not only increased illness but even death. The medical profession has been slow even in the face of such indications to adopt a definite scheme of prophylaxis. We have been very vague in the advice we have given such patients, and too often a pregnancy has occurred in such physically unfit individuals and the physician has found it necessary to interrupt the pregnancy in order to avoid jeopardizing the patient's health or to prevent the loss of life.

The medical profession should also recognize the fact that in some patients the bearing of children in quick succession may often have an injurious effect on a patient's health. Many a strong individual has had her health ruined by pregnancies that occurred in too rapid succession. These patients with organic disease and with poor

health due to frequent childbearing present a positive demand for some type of contraceptive.

Besides these maternal considerations, something can be said from the standpoint of the offspring. Not only can a mother's health be jeopardized by a pregnancy occurring in the presence of certain diseases, but the future of the offspring may be materially affected. Since choice of birth is not voluntary with a child, it should at least have the right of being born with a sound body and mind. Syphilologists agree that conception should not occur during the active stages of syphilis.

Psychiatric conditions likewise are a handicap for any child. An ounce of prevention is here worth a pound of cure. In all fairness to the child as well as to society at large, we feel that patients with psychiatric conditions should not reproduce their kind.

Besides these medical reasons for the control of pregnancy, other reasons make a strong demand. Social conditions often make it desirable that the occurrence of pregnancy should be controlled. We recognize the fairness of the patient's request that she be given the right to regulate her childbearing, and space her pregnancies at more or less definite intervals. By so doing the mother can concentrate her attention on one child up to a certain point before the next one demands a repetition of her service. It would change the mother's life from one of involuntary drudgery to one of voluntary service. There can be no doubt that the undesired pregnancy is the cause of the abortion tragedy of this age. The intelligent use of an efficient prophylactic method would do a great deal towards solving the abortion evil, and prevent the high mortality and morbidity accompanying it.

Our standards of living, whether right or wrong, are now such that the rearing of a large family is becoming more and more difficult and we feel there is a great deal of justice in the patient's assertion that she prefers to bring up a smaller family to a higher standard, rather than a larger family to a lesser standard.

The social indication for birth control is closely allied to our economic situation, and never has it been more opportune to give thought to this question than at the present moment. In many families the economic situation is such that the question of proper obstetrical care is a problem and the care of

an additional child on the limited income creates almost a hopeless despair. Among the indigent this is an important social problem and a small investment in a contraceptive clinic may save the community a large welfare budget at a later date.

The statement is sometimes made that if the knowledge of contraceptive measures becomes too general the human race will gradually decrease. One making such an assertion is plainly not acquainted with the facts. The population of Holland, for instance, has not suffered seriously from publicity of birth control matters, although Holland has had birth control clinics since 1878. The maternal instinct is present in nearly all women, and most women will sooner or later have the desire to have a child, and when that wish springs up within her no amount of birth control propaganda will prevent her from having her desire. It is a common experience to discover that patients to whom contraceptive advice has been given return in a pregnant state and on analysis we learn the pregnancy was wanted and did not occur because of failure of the contraceptive method. The future of the race will always be safe because of this maternal instinct.

The birth control movement is often subjected to criticism on the ground that it will encourage immorality. This may be viewed from a different angle, however. It is more logical to deduce that birth control by encouraging earlier marriages will be a definite factor in reducing extra-marital sex relations. Francis Place in 1822 wrote that he virtually owed his moral salvation to a very youthful marriage, but that this same marriage had burdened him with fifteen children and filled his early years with the hardest poverty. He concluded that the only solution of the poor man's population problem was early marriage and limitation of family. He gives his views in "Illustrations and Proofs of the Principles of Population," published in 1822.

In all our discussion of this problem, we must not lose sight of the fact that it is one thing to be enthusiastic over the idea or principle of birth control, and another thing to solve the practical technic. We feel that womankind at large should have the right to control, if possible, her offspring. In advocating this we must not forget that the successful use of our present methods of contraception depends somewhat on the pa-

tient having mentality enough to follow instructions closely. We face the fact that we may successfully control reproduction of the intelligent, but run the risk of failing with those of lesser intelligence. This would create an unfortunate state of affairs and would be a violation of the principle of eugenics. A great deal of research must still be done to discover if possible a simple contraceptive method that will not require too much intelligence to use. We must remember that there are still limitations to the practice of contraception.

The knowledge that our methods are still far from perfection causes us at times to stand somewhat awed at the enthusiasm displayed by some individuals who apparently seem to think that if the world will only embrace the idea of contraception and endorse the principle, that then the problem will be solved. Intelligent enthusiasm and zeal will help any cause. Scientific research in this field is only in its infancy and it is here where a great deal of effort must be spent in order to find a solution for this problem.

Members of the medical profession in general have not been leaders in this movement. A great deal of writing on this subject had been done by philosophers and socially inclined thinkers before the first contribution by a medical man appeared. This contribution was by Dr. Charles Knowlton in 1833 and his pamphlet, previously referred to, was entitled "Fruits of Philosophy." This was followed in 1854 by "The Elements of Social Science," by Dr. George Drysdale. In 1912 Dr. Abraham Jacobi in his presidential address before the American Medical Association endorsed hygienic prevention of pregnancy. In 1924 Dr. William A. Pusey in his presidential address before the same society urged the necessity of contraceptive work. In 1923 the New York Obstetric Society determined to include the birth control problem as a part of its program. The resulting committee which was formed and of which Dr. R. L. Dickenson was Secretary did a great deal of research work, and as a result the propaganda for birth control has been supported by scientific work of medical men. Although contraceptive methods had been taught in Holland for considerable time this committee of American medical men deserve the credit for placing this work on a scientific basis. By a system of follow-up work the efficacy

of the different methods of contraception was studied.

Although certain medical men have thus helped in the solution of this problem, the general rank and file of the profession have to a large extent been indifferent or lukewarm to all proposals. Due to the work and enthusiasm of Margaret Sanger the propaganda has been spread far and wide and the demand for information on this subject has been created. The idea is here, and doubtless here to stay. Medical men must decide what their attitude will be. The movement still requires a great deal of sane judgment, and there is still room for medical men to exert their influence and assert their leadership.

The legality of birth control advice or practice is often questioned. This phase of the problem dates back to 1869 when, as previously mentioned, Anthony Comstock succeeded in inducing the legislature of the State of New York to include birth control information in an obscenity law, and in 1873 through Comstock's efforts Congress enacted a statute excluding information concerning contraception from the United States mails, and declaring such information illegal and obscene. In 1918 Judge Crane of the New York Court of Appeals decided that the legally practicing physician can legally give contraceptive advice for the protection of health and the prevention of disease.

About one-half of the States in this country mention prevention of conception in their laws in some guise or other. The Michigan law is as follows:

"The publication or sale within this State of any circular, pamphlet or book containing recipes or prescriptions in indecent or obscene language for the cure of chronic female complaints or private diseases, or recipe or prescription for drops, pills, tinctures, or other compounds designed to prevent conception, or tending to produce miscarriage or abortion is hereby prohibited and for each copy thereof so published and sold, containing such prohibited recipes or prescriptions, the publisher and seller shall each be deemed guilty of a misdemeanor and shall be liable to same penalties for a violation of preceding section."

This is interpreted as intending to prohibit the publishing and distribution of information on prevention of conception. It does not prohibit publishing a discussion on the

subject of birth control, and it does not prohibit the giving of verbal information or advice on prevention of conception. Thus the giving of contraceptive advice is legal in this State as long as the advice is given verbally.

One of the chief activities of the American Birth Control League is the effort it is making to so change our Federal laws that birth control literature will no longer be classed as obscene literature and will no longer be denied transportation via United States mail.

As mentioned before, the birth control movement still offers opportunity for leadership and guidance to medical men. The movement deserves the support of medical men as individuals as well as that of medical organizations. The problem is as yet by no means solved. There is still room for study and research. The movement is shackled by antiquated laws. Medical men can have a great influence in the dictating of

sane laws. We bespeak for the movement the sympathy, support and endorsement of medical men not only as individuals, but as an organized professional group.

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 1807 DAVID WHITNEY BLDG.

CHRONIC POLYPOID MAXILLARY AND ETHMOID SINUSITIS WITH ASTHMA*

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 CASE REPORT

The relation between paranasal sinusitis, especially of the polypoid type, and some cases of asthma has been recognized for years. Whatever may be the primary cause of asthma in a given case, nasal pathology may be the trigger causing the explosion of the asthmatic attack. An asthmatic paroxysm may be looked upon as a reflex neurosis depending upon afferent irritation of the trigeminal nerve endings in the nose on the efferent vagus nerve fibres through their connections via the bulbar nuclei of these nerves. For example, cocaine to the nasal mucous membrane may in some instances stop an asthmatic attack. The following is a case of bronchial asthma co-existent with polypoid degeneration of the mucous membrane of all the paranasal sinuses, most pronounced in the ethmoid and maxillary sinuses.

Mr. C. W., age 53, was a former salesman by occupation. He was first seen in the clinic on June 8, 1931. His chief complaint consisted of difficult breathing through the nose, asthmatic attacks day and night, continuous clearing of his throat, a watery nasal discharge and some frontal headaches. He stated his trouble began with bronchitis 12 years

ago. He has had nasal blockage ever since. His asthmatic attacks are not seasonal. He further stated that he had had 145 foreign protein skin tests, all of which were negative.

The general physical examination of the patient was essentially negative, except for an asthmatic chest. With relation to the upper respiratory tract much of interest was found. In the nose there was seen a double serous nasal discharge in both anterior nares, the septum badly deviated to the right anteriorly.

There were multiple polypi in the left nares; some were also present in the right nares, but these were seen better after shrinkage of the mucous membrane. Following suction there was a heavy purulent discharge apparently from both middle meati. On posterior rhinoscopy several small polypi were seen in the nasopharynx. All sinuses were definitely cloudy on transillumination and X-ray films showed

*Read before the monthly staff meeting at Grace Hospital, Detroit, Michigan, November, 1931.

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a pansinusitis, but with most of the involvement in the maxillary and ethmoid sinuses.

The throat showed a mild chronic tonsillitis, and the larynx showed a chronic injection of the entire mucous membrane, including that of both vocal cords. Blood examination revealed a negative Kahn, 10 mg. of calcium per 100 c.c., and a practically normal red and white cell count. The urine was negative. X-ray plates of the chest revealed a moderate degree of the hilar lymph gland enlargement and some emphysema throughout the entire lung fields. The heart shadows were normal.

On June 20, 1931, I advised a submucous resection, a double ethmoidectomy, and a double radical antrum operation. Nine days later this procedure was done under local anesthesia and extensive polypoid degeneration of all the sinuses named was found. Sections were made for microscopic study of the polypoid tissue and it showed very strikingly a high degree of eosinophilia. Mosher, of Boston, and his co-workers claim that this is quite a constant finding in the mucous membranes of the paranasal sinuses where the condition co-exists with asthma and certain other allergic phenomena.

His postoperative condition was good and he had complete relief of headaches and asthma. After four days in the hospital he was discharged, and was seen thereafter at three to four day intervals in the clinic. The treatment consisted of removal of debris and irrigation with normal saline solution of each maxillary sinus through the antral windows.

On July 30, he contracted an acute coryza with some asthmatic recurrence. The antral windows remained well open, the incisions in each canine fossa were entirely healed, but pus drained freely from the ethmoid labyrinths. The nasal passages were irrigated with saline solution and argyrol packs were inserted into these areas and the patient was given sodium bicarbonate, grains 10 every three hours, for alkalinization.

On August 8, he was again seen and it was found that he still had some asthma but the coryza was gone. The breathing space in his nose was very good.

On the next visit, August 13, the patient's general condition was very much improved, had occasional asthmatic attacks, but these were more at night

and were not continuous. A small piece of polypoid tissue was removed from the right posterior ethmoid area with a nasal snare; otherwise airways were entirely clear, no other polypi were to be seen and nasal breathing was entirely reestablished.

On September 5, he still had some asthma and a bronchoscopy was deemed advisable and he was referred to Drs. Hudson and Birch for that procedure. I quote their findings verbatim: "A seven millimeter bronchoscope was passed in the usual manner. The trachea was found to be non-spastic but contained a large amount of thick, tenacious secretion. Both bronchi were filled with secretion of the same character and this was removed by suction."

"On September 22, a similar examination was made and the bronchoscope passed more easily into the left and right stem bronchi. A moderate amount of spasm was present. Much less thick tenacious secretion was aspirated."

"The third and last bronchoscopic examination was made on September 29, and only a slight amount of secretion and practically no spasm were present in each stem bronchus. In general the patient showed very marked improvement at that time."

The patient was lost sight of until March 26, 1932, when he returned to the clinic. He reported he had no asthma, had gained 15 pounds in weight. His nasal passages were clear, no polypi or discharge were seen. He said he had had a few mild "head colds" but even these did not cause any asthmatic attacks.

I report this case merely as a record of events in the diagnosis and treatment of it and have purposely avoided the discussion of the allergic aspect, although I do not deny that it probably existed.

My thanks are due to Drs. W. A. Hudson and J. R. Birch for their kindness in performing the bronchoscopic examinations and for helpful suggestions.

1026 MACCABEES BLDG.

MICHIGAN'S DEPARTMENT OF HEALTH

C. C. SLEMONS, M.D., Dr.P.H., Commissioner
LANSING, MICHIGAN

POLIOMYELITIS

The Michigan Commission on Infantile Paralysis held a meeting on June 22 and made organization plans for providing consultant service and convalescent serum during the "poliomyelitis season" this year.

The state has been divided into 16 districts with a district director in charge of each. These district directors have appointed such consultants as they considered necessary. No funds are provided by the commission for consultant service and those physicians who are acting as consultants will collect in the usual way from the individual.

Convalescent serum is again provided without charge for those cases for whom it is recommended by the consultant.

Up to the date of this writing, July 30, there has been no indication of an outbreak such as occurred last year. The number of cases reported from July 1 to July 30 is 6, as compared to 29 for the same period last year.

Physicians desiring consultant service and convalescent serum should call the director of their district or a consultant appointed by that director. The list of districts and the director for each is as follows:

1. Dr. Moses Cooperstock, Director, Marquette
All Upper Peninsula—15 counties
2. Dr. Carleton Dean, Director, Charlevoix
Emmet, Charlevoix, Otsego, Antrim, Grand
Traverse, Leelanau—6 counties
3. Dr. R. B. Howard, Director, Rogers City
Cheboygan, Presque Isle, Montmorency, Al-
pena—4 counties
4. Dr. S. C. Moore, Director, Cadillac
Wexford—1 county
5. Dr. Stanley A. Stealy, Director, Grayling
Kalkaska, Crawford, Missaukee, Roscommon
—4 counties
6. Dr. T. H. Johnston, Director, West Branch
Oscoda, Alcona, Ogemaw, Iosco—4 counties
7. Dr. L. J. Schermerhorn, Director, Grand Rap-
ids National Bank Bldg., Grand Rapids
Oceana, Newaygo, Mecosta, Muskegon, Ben-
zie, Montcalm, Mason, Lake, Osceola, Manis-
tee, Ottawa, Kent, Ionia—13 counties
8. Dr. L. F. Foster, Director, Shearer Bldg., Bay
City
Clare, Gladwin, Arenac, Isabella, Midland,
Griatiot, Saginaw, Bay—8 counties
9. Dr. Lafon Jones, Director, Genesee County Sav-
ings Bank Bldg., Flint
Huron, Tuscola, Sanilac, Genesee, Lapeer,
Saint Clair—6 counties
10. Dr. E. I. Carr, Director, Medical Bldg., Lansing
Clinton, Shiawassee, Eaton, Ingham, Living-
ston—5 counties
11. Dr. A. B. Mitchell, Director, Allegan
Allegan, VanBuren, Berrien, Cass—4 counties
12. Dr. M. R. Kinde, Director, Hastings
Barry—1 county
13. Dr. John Lavan, Director, City Hall, Kalamazoo
Kalamazoo, St. Joseph—2 counties
14. Dr. H. F. Becker, Director, 61 W. Main St.,
Battle Creek
Calhoun, Branch—2 counties
15. Dr. J. P. Parsons, Director, University of
Michigan, Ann Arbor
Oakland, Macomb, Jackson, Hillsdale, Lena-
wee, Monroe, Washtenaw, Wayne (excluding
Detroit)—8 counties
16. Dr. J. E. Gordon, Director, Detroit Department
of Health
Detroit City

Note: The Commission provides serum without cost for those cases approved by Regional Directors or their duly appointed consultants, but does not provide compensation for services of consultants.

TYPHOID FEVER

Typhoid fever incidence is considerably higher this year than for several previous years. Not only has there been a number of small outbreaks, but also a greater than usual number of sporadic cases. Typhoid fever is by no means completely eliminated in Michigan.

Physicians are urged to be on the lookout for cases and to report all cases to the local health officer as early as possible. Patients suspected of having typhoid should be reported promptly so that investigation of possible sources may be started without the delay that often results from waiting for development of clinical characteristics and positive laboratory findings.

Family and other close contacts should be immunized promptly. The delay in waiting for a positive diagnosis in the first case before immunizing the contacts often results in secondary cases.

No harm is done if investigation for a possible source is started by the health officer for a suspected case which afterwards proves not to be typhoid. Likewise no harm is done by immunizing contacts of such a suspected case.

BIOLOGICS

All physicians in the state are being furnished with cards giving a list of the biologics supplied without cost to any physician in Michigan by the Michigan Department of Health. Where the city or the county health officer keeps a supply of these biologics in stock, physicians will find it to their advantage to secure them from that source. Where this is not the case, the Michigan Department of Health will promptly take care of any requests.

The list of biologics furnished by the Michigan Department of Health is as follows:

BIOLOGIC PRODUCTS MANUFACTURED AND DISTRIBUTED BY MICHIGAN DEPARTMENT OF HEALTH

in coöperation with

UNITED STATES PUBLIC HEALTH SERVICE

U. S. Government License 99

Diphtheria Antitoxin, 1000 units
Diphtheria Antitoxin, 10000 units
Diphtheria Antitoxin, 20000 units

Diphtheria toxin for Schick test, 1 c.c. vials, 10 tests
Diphtheria toxin for Schick test, 10 c.c. vials, 100 tests
Diphtheria toxin for Schick test, heated control, 1 c.c. vial, 10 tests
Diphtheria toxin for Schick test, heated control, 10 c.c. vial, 100 tests

Diphtheria Toxoid for active immunization, 1 complete treatment package
Diphtheria Toxoid for active immunization, 10 c.c. vials
Diphtheria Toxoid for active immunization, 50 c.c. vials
Diphtheria Toxoid for reaction test, 1 c.c. vials

Scarlet fever antitoxin, therapeutic dose

Scarlet fever toxin for active immunization, 1 complete treatment package

Scarlet fever toxin for Dick test, 10 c.c. vials, 100 tests

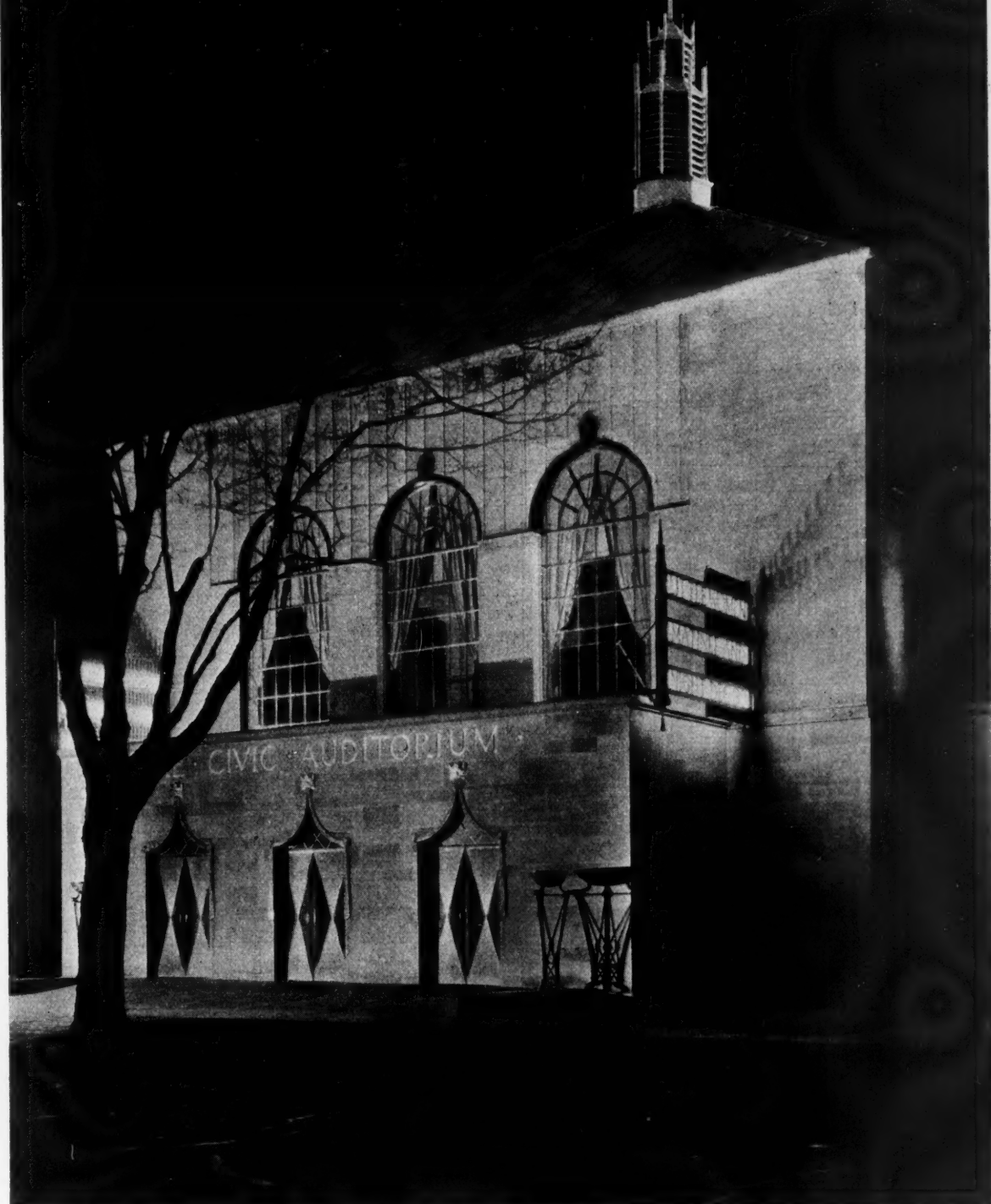
Smallpox vaccine, 2 tube package
Smallpox vaccine, 5 tube package
Smallpox vaccine, 50 tube package

Silver nitrate, 1½%, 5 ampoules per package

Typhoid vaccine, 1 c.c. vials
Typhoid vaccine, 10 c.c. vials

(Continued on Page 615)

KALAMAZOO • CIVIC • AUDITORIUM



112TH ANNUAL MEETING—OFFICIAL PROGRAM—KALAMAZOO, SEPTEMBER 13-15, 1932

OFFICIAL PROGRAM

112th Annual Meeting Michigan State Medical Society
September 13, 14 and 15, 1932

OFFICIAL CALL

The Michigan State Medical Society will convene in annual session in Kalamazoo on Sept. 13, 14, 15, 1932. The provisions of the Constitution and By-laws and the official program will govern the deliberations.

CARL F. MOLL, *President*

B. R. CORBUS, *Chairman Council*

H. J. PYLE, *Speaker*

Attest:

F. C. WARNSHUIS, *Secretary*

MEETING PLACE

FIRST PRESBYTERIAN CHURCH HOUSE and
CIVIC AUDITORIUM

CHURCH HOUSE

Registration

Exhibits

House of Delegates

CIVIC AUDITORIUM

General Sessions

Combined Sectional Meetings

CONDENSED DAILY SCHEDULE

Tuesday (Sept. 13)	Wednesday (Sept. 14)	Thursday (Sept. 15)	Memorandum
10:00 A.M. House of Delegates	9:15 A.M. Section Meetings Medicine Surgery Gynecology and Obstetrics E. E. N. and T. Pediatrics Dermatology	9:15 A.M. Section Meeting Medicine Surgery Gynecology and Obstetrics E. E. N. and T. Pediatrics Dermatology	1. Registration: Church House 2. Scientific and Commercial Exhibits: Church House 3. Combined Meetings: Civic Auditorium 4. General Meeting: Civic Auditorium 5. House of Delegates: Civic Auditorium 6. Section Meetings: See Bulletin Board —o—
Afternoon	Afternoon	Afternoon	
2:30 P.M. House of Delegates	1:15 P.M. Combined Meeting [All Sections]	1:15 P.M. Combined Meeting [All Sections]	
7:30 P.M. House of Delegates	7:30 P.M. General Meeting President's Address	7:45 P.M. Public Meeting Morris Fishbein, M.D. Address	NOTICE Do not fail to visit Scientific and Commercial Exhibits in Church House. —o—

GENERAL MEETING

Wednesday Evening, September 14, 1932

Time: 7:45 P. M.

Place: Civic Auditorium.

1. Musical Prelude.
2. Invocation: Rev. John W. Dunning.
3. Welcome: R. A. Morter, President Kalamazoo Academy of Medicine.
4. Report from House of Delegates.
5. Ideals of the Profession—Dr. Olin West, Secretary and General Manager, American Medical Association, Chicago.
6. President's Annual Address: "Some Phases of Medical Economics"—Carl F. Moll, M.D., Flint.

7. In Memoriam—the Secretary.
8. "Leadership in the Solution of National and Local Health and Medical Problems"—E. H. Carey, M.D., President American Medical Association, Dallas, Texas.
9. Introduction of President-Elect.
10. Induction in Office of J. Milton Robb, M.D., Detroit.
11. Adjournment.

Second General Session

Thursday Evening, September 15, 1932

Time: 8:00 P. M.

Place: High School Auditorium.

1. Introductory Remarks: R. A. Morter,

President Kalamazoo Academy of Medicine.

2. "The Communities' Responsibility to the Medical Profession," Morris Fishbein, M.D., Editor Journal American Medical Association, Chicago.

COMBINED SECTION MEETINGS

CIVIC AUDITORIUM

Wednesday, September 14—1:15 P. M.

1. "Allergy in Medical Practice"—Warren Vaughan, M.D., Richmond, Va.
2. "Can the Person with Heart Disease Stand an Operation?"—Samuel A. Levine, M.D., Boston.

Three questions arise that a physician has to answer:

- (1) Is the condition for which the surgeon wishes to operate really surgical? Some cardiac disorders resemble an acute surgical abdomen.
- (2) Does the patient with organic heart disease merit the surgery that is being contemplated? The prognosis of the heart may be too brief to warrant an operation for which there is available palliative medical treatment.
- (3) What is the increased risk in an operation that is to be performed, because of the heart disease that is present? As to the latter, most compensated hearts stand an operation satisfactorily.

3. "Mammary Neoplasms"—R. R. Smith, M.D., Grand Rapids.
4. "The Treatment of Pneumonias"—George E. McKean, M.D., Detroit.
Following the discussion of the evolution in the understanding of pneumonia, there will be a résumé of the standard bedside handling of a patient with the disease and an evaluation of the efficacy and applicability of the various specific and non-specific anti-sera available at present.
5. "Perforated Acute Gastric Ulcers"—H. K. Shawan, M.D., Detroit.
6. Talking Motion Pictures—"Cardiac, Vasomotor and Respiratory Phenomena"; "Signs and Symptoms of Raised Intra-cranial Pressure" (Courtesy Petrolagar Laboratories).

No discussions during afternoon sessions.

Thursday, September 15—1:15 P. M.

1. "The Diagnosis of Mastoiditis and Its More Frequent Complications"—Millard F. Arbuckle, M.D., St. Louis, Mo.
Review of the history of conditions prior to and the etiological factors concerned in acute mastoiditis.
Appearance of the anatomical parts concerned, with discussion of the changes occurring during each stage of the disease.

Discussion of the signs and symptoms of the more frequent complications with suggestions as to treatment.

2. "Posture"—Joel E. Goldthwait, M.D., Boston, Mass.

The importance of the proper mechanical function of the different parts of the body as the basis of health, and especially as it concerns the problem of the chronic patient. This, as you will see, treats of the correct use of the body, which, in one sense, means proper posture, but treats it more as a scientific matter and deals, naturally, with not only the mechanics of the skeleton and muscular tissue but with reference to the viscera and all that concerns health, and much of that which concerns life.

3. "Diagnosis and Management of Premature Detachment of Normally Implanted Placenta"—Fred Falls, M.D., University of Illinois, Chicago.
4. "Treatment of Varicose Veins"—Eugene A. Osius, M.D., Detroit.
Milne C. Harvey, M.D., Detroit.
5. Talking Motion Picture: "Maggot Treatment for Chronic Osteomyelitis." (Courtesy Petrolagar Laboratories.)

SCIENTIFIC PROGRAM

General Medicine

Chairman: RICHARD M. McKEAN, Detroit.
Secretary: IRVING W. GREENE, OWOSSO

September 14—9:15 A. M.

1. Chairman's Address—"Diabetes and Tuberculosis"—Dr. Richard M. McKean, Detroit, Michigan.

The basis for this discussion lies in the observation over a period of better than three years, of a group of patients afflicted with both of the above diseases. The importance of the maintenance of a normal blood sugar level by means of diet and insulin is stressed. With this major premise fulfilled, the tuberculosis may be treated as in the non-diabetic not including such major surgical procedures as thoracoplasty, although careful observation from the diabetic side again is a necessary factor during this period. A few descriptive cases will be outlined to emphasize the frequent success attendant on the coöperative management of both the tuberculosis and diabetes by individuals familiar with the modern development in these two fields.

2. "New Concepts in the Treatment of Diabetes"—Dr. L. H. Newberg, Ann Arbor, Michigan.

Current literature states that the ability of a diabetic to metabolize glucose is increased by adding carbohydrate to the diet and decreased by fat and by full maintenance diets. The authors deny this, for properly planned experiments show that the tolerance (ability to

metabolize glucose) is related solely to the total glucose of the diet (metabolic mixture). The number of grams of glucose metabolized by a unit of insulin is proportional to the excess of glucose beyond tolerance until a maximum is reached. A diabetic whose tolerance was 76 grams glucose required 10 units of insulin when he took 90 grams glucose. Each unit disposed of 1.4 grams. An intake of 106 grams also required 10 units, giving an efficiency of 3. When 123 grams of glucose were taken, 10 units of insulin were still sufficient. The efficiency was now 4.7. An intake of 174 grams required 14 units. The efficiency of 7 now reached could not be increased, for an intake of 274 grams required 30 units, indicating an efficiency of 6.8.

Discussion—Dr. Don H. Duffie, Central Lake, Michigan; Dr. Daniel P. Foster, Detroit, Michigan.

3. "Nephritis"—Dr. Floyd H. Lashmet, Ann Arbor, Michigan.

The process of excretion of waste products in renal disease is fundamentally one which avoids the retention of solids by increasing the water output as a compensation for a low concentrating ability. In renal disease, regardless of type or whether edema is present or absent, an enormous fluid intake is imperative if retention of wastes is to be avoided.

Discussion—Dr. Alpheus Jennings, Detroit, Michigan; Dr. W. H. Marshall, Flint, Michigan.

4. "Arteriosclerosis and Hypertension"—Dr. C. G. Jennings, Detroit, Michigan.

Arterial hypertension may be primary, essential hypertension or secondary, a complication of one of several diseases. May be benign or malignant. Etiology. Relation of hypertension to arteriosclerosis. Three forms of arteriosclerosis—diffuse hyperplastic sclerosis, atherosclerosis, derescent arteriosclerosis. Each form has distinctive etiology, pathology, and symptoms. Each may exist alone or combined with others. Clinical histories of three forms. Demonstration of pathology and laboratory findings with lantern slides.

Discussion—Dr. C. C. Sturgis, Ann Arbor, Michigan; Dr. Plyn Morse, Detroit, Michigan.

5. "Treatment of Acute Coronary Thrombosis"—Dr. Samuel Levine, Boston, Massachusetts.

There are many patients with acute coronary thrombosis who die despite everything we can possibly do. There are many others who recover satisfactorily if nothing is done. There remain a few in whom proper therapy will make the difference between life and death. The physician, therefore, must be able to detect the various complications that can arise and institute proper treatment.

Discussion—Dr. Frank Wilson, Ann Arbor, Michigan; Dr. Earl D. Spaulding, Detroit, Michigan.

Dr. Levine is Assistant Professor of Medicine at the

Harvard Medical School, Senior Associate in Medicine at Peter Bent Brigham Hospital, Boston, Massachusetts, and Visiting Physician at Beth Israel Hospital, Boston, Massachusetts.

September 15—9:15 A. M.

Election of Officers

1. "The Classification, Etiology and Present Status of the Treatment of Chronic Arthritis"—Dr. Joseph L. Miller, Chicago, Illinois.

There is need for classification in this disease because there is great confusion at the present time. Two very distinct types can be recognized and if we combine with these the mixed forms—that is, where both types are combined in the same patient—practically every case can be classified.

The pathology of the joint shows that we are dealing with two diseases of distinct etiology. Osteo-arthritis is due to mechanical irritation or trauma and not to infection; rheumatoid arthritis is an infective disease.

In regard to treatment, I will discuss the importance of focal infections; the use of vaccines; orthopedic measures; and diet.

Discussion—Dr. Hugo A. Freund, Detroit, Michigan; Dr. Carl E. Badgley, Ann Arbor, Michigan.

Dr. Miller is Clinical Professor of Medicine at the University of Chicago Clinic and Attending Physician at St. Luke's Hospital.

2. "Migraine, Particularly as an Allergic Manifestation"—Dr. Warren T. Vaughan, Richmond, Virginia.

Discussion—Dr. Carl D. Camp, Ann Arbor, Michigan; Dr. Frank R. Menough, Detroit, Michigan.

Dr. Vaughan was born in 1893. He graduated from the University of Michigan in 1916. He is a member of the American Society of Clinical Pathologists and the author of many articles on the subject of allergy.

3. "Neurological Diagnosis"—Dr. Carl D. Camp, Ann Arbor, Michigan.

The neurological examination consists of three distinct parts. First a study of the reflexes, the motor functions of the body, and the sensory perceptions. The object of which is to determine the location and extent of destructive lesions of the nervous system. The second phase includes such examinations as the spinal puncture, the determination of spinal block, the chemical and bacteriological examination of the spinal fluid, the making of encephalograms, etc. The object of these studies is also of localizing importance, but often throws light on the nature of the lesion as well. The third phase might be called the psychoanalysis, which includes much more than ordinary history taking. The important facts are only elicited by an exploration of the subconscious. The methods used are free association, reaction time tests, dream analysis, etc.

Discussion—Dr. Fred P. Currier, Grand Rapids, Michigan; Dr. Gordon Brain, Flint, Michigan.

4. Joint meeting with the Surgical Section.

Clinical Pathological Conference
—Medical Discussion: Dr. Cyrus C. Sturgis, Ann Arbor, Michigan.

Surgery

Chairman: JOHN ALEXANDER, Ann Arbor.
Secretary: G. J. CURRY, Flint.

September 14, 1932—9:00 A. M.

1. "Intestinal Obstruction"—Dr. R. L. Mustard, Battle Creek.

Discussion—H. K. Ransom, A.B., M.D., Ann Arbor; R. S. Morrish, B.S., M.D.

2. "Pre-Operative Care of Patient"—Dr. R. H. Baker, Pontiac.

The present status of the surgical specialist, in relation to patient, hospital and laboratory; his obligation in obtaining careful history and physical examination. Preparation of the patient, mentally, physically, locally. Suggestions concerning fluid balance, and preparation for special fields of surgery. Preparation and selection of anesthetic, with special reference to general versus spinal anesthesia. Summary: A plea for elimination of complicated traditional routine and emphasis on simplicity with due regard to physiological needs.

Discussion—W. L. Finton, M.D., Jackson; A. L. Arnold, Jr., M.D., Owosso.

3. "Post-Operative Care of Patient"—Dr. F. A. Collier, Ann Arbor.

Studies of end-results emphasize the frequency of postoperative complications, many of which can be anticipated and prevented. The common complications such as dehydration, distention, acidosis and alkalosis are discussed, with suggestions for treatment.

Discussion—Geo. L. LeFevre, M.D., Muskegon; G. Seibold, M.D., Jackson.

4. "Traumatism of the Brain"—Dr. H. E. Randall, Flint.

Subject of brain injuries introduced by four brief reports to illustrate pathology, symptoms, diagnosis, and care of these cases. Glucose in shock and edema. Better results both immediate and remote by dehydration, spinal puncture and drugs. Operations necessary but last resort, and should be fewer in number.

Discussion—M. M. Peet, M.A., M.D., Ann Arbor; A. S. Crawford, B.S., M.D., Detroit.

5. "Empyema"—Dr. S. W. Harrington, Rochester, Minn.

Discussion—E. J. O'Brien, M.D., Detroit; Clyde I. Allen, Detroit.

6. "A New Method of Skin-graft."—C. V. Russell, M.D., Lansing.

Morning, Dry Clinic

September 15, 1932—9. A. M.

1. "Diagnosis and Treatment of Goiter."—Dr. C. E. Boys, B.Sc., Kalamazoo.

An informal résumé with the exhibition of patients to illustrate.

The non-toxic case. The typical goiter with toxicity and the results of thyroidectomy. The toxic thyroid with few clinical symptoms and negative B.M.R. The relation of a high toxicity and a pathological report of "simple colloid." The relation of goiter to insanity. Failures and recurrences.

2. "Important Little Things in the Treatment of Anal Diseases"—Dr. L. J. Hirschman, Detroit.

3. "Amputations, with Particular Reference to Preparation of the Stump"—Dr. C. E. Badgley, Detroit.

4. "New Methods of Relieving Prostatic Obstruction"—Dr. Reed Nesbit, Ann Arbor.

5. "Management of Colles Fracture"—Dr. Grover C. Penberthy, Detroit.

General discussions on each paper lasting three minutes.

Gynecology and Obstetrics

Chairman: N. F. MILLER, Ann Arbor

Secretary: H. A. FURLONG, Pontiac.

First Day—September 14, 1932

9:00 A. M.

1. Chairman's Address—Dr. N. F. Miller, Ann Arbor, Michigan.

2. "Functional Disorders of the Ovary"—Dr. J. P. Pratt, Henry Ford Hospital, Detroit, Michigan.

Functional disorders of the ovary are more common than organic lesions. Diagnosis of the type and degree of disorders should precede therapy. Variations from normal functions are often difficult to determine. Menstrual irregularities are most easily observed indicators of the state of ovarian function. Classification of ovarian disorders is difficult. Results of treatment are compared.

3. "The Gynecological Symptoms in the Maladjusted Woman"—Dr. B. W. Malfroid, Flint, Michigan.

In Gynecology today increasing emphasis is being placed on the influence of environment and social adjustments upon the emotional reactions of the patient. Changing social and economic conditions of modern life and their reflection in various physical signs and symptoms among women are discussed and illustrated with case reports.

4. "Prenatal Care and Its Importance"—Dr. Howard O. Brush, Port Huron, Michigan.

The importance of prenatal care and its newer aspects are stressed. Just what the obstetrician can hope to accomplish, especially in the prevention of toxemias, is given prime consideration.

5. "A Consideration of Puerperal Infection"—Dr. M. J. Lieberthal, Ironwood, Michigan.

The ever present hazard of puerperal morbidity and mortality warrants repetition and consideration of etiological factors as well as newer methods of treatment. A case report of a patient with unusual complications is included.

Second Day—September 15

9:00 A. M.

1. "Scopolamine Alone for the Relief of Pain During Labor"—Dr. L. E. Daniels, Detroit, Michigan.

The results of the use of scopolamine in five hundred labors for the production of amnesia and analgesia without morphine is discussed. The advantages and disadvantages over other common drugs are presented. Its effect upon the baby and mother, and its limitations are considered.

2. "The Use of Sodium Amytal and Avertin in Obstetrics"—Dr. W. C. Ellet, Benton Harbor, Michigan.

The use of sodium amytal and avertin, in the opinion of the author, has a proper and useful field in obstetrics. Without considerable contra-indications or dangers, it approaches closely the ideal obstetrical anesthesia. The apparent synergistic action of these two drugs is considered.

3. "Contraception"—Dr. E. M. Matsner, New York, Medical Director, American Birth Control League.
4. "Sodium Amytal and Pernocton in Obstetrics"—Dr. B. L. Lieberman, Detroit, Michigan.

The methods of administration and results from the use of these drugs during labor are discussed by the author. The drawbacks as well as the advantages are carefully considered.

Pediatrics

Chairman: T. D. GORDON, M.D., Grand Rapids

Secretary: CAMPBELL HARVEY, M.D., Pontiac

First Session

September 14, 1932—9:00 A. M.

1. "Bacteriophage"—Dr. N. W. Larkum, Lansing.
2. "Cod Liver Oil Concentrates"—Dr. D. J. Barnes, Detroit.
3. "Anomalies of the Genito-urinary Tract in Children"—Dr. C. M. Spooner, Toronto, Ont.
4. "Infantile Eczema"—Dr. Francis E. Seneear, Chicago.
5. Open.

Second Session

September 15, 1932—9:00 A. M.

Election of Officers.

1. "The Relation Between Cerebral Diplegia and Birth Injury"—Dr. T. D. Gordon, Grand Rapids.
2. "Therapeutic Radiology in Relation to Infancy and Childhood"—Dr. A. U. Desjardins, Mayo Clinic, Rochester.
3. "Congenital Heart Disease with Reports of Cases"—Dr. W. J. Wilson, Detroit.
4. "Behavior Problems in Children"—Dr. Barnes, Department of Pediatrics, Ann Arbor.
5. Reserved for Pediatrics Department, Ann Arbor.

Ophthalmology and Otolaryngology

Chairman: WILFRID HAUGHEY, Battle Creek

Secretary: H. O. WESTERVELT, Benton Harbor

Wednesday, September 14—9:30 A. M.

1. Chairman's Remarks. Dr. Wilfrid Haughey, Battle Creek.
2. "Prevention and Non-Surgical Treatment of Cataracts"—Dr. Alfred Dean, Grand Rapids.

The ophthalmoscope has been responsible for clearing up many of the early false conceptions of cataract, but it did not correct the etymology of the term. With improved technique and observation, cataracts have received a more definite classification. While it may commonly be considered as a result of senile degeneration, it is more often a secondary

condition, resulting from local or systemic causes which might be prevented by observation of rules of hygiene and sanitation.

The location of the lens, with its source of nutrition and its duties, exposes it to early injury from internal and external causes, so that it may be one of the first tissues to manifest signs of pathology.

The slit-lamp has given us much valuable information that was beyond our reach with the ophthalmoscope, and gives its operator living material to study microscopically, and, as a result, local or systemic effects on the lens tissue are now recognized as producing a more or less characteristic picture.

Prevention is the treatment of choice, but if acquired opacities in the lens do develop, there is more to be offered the patient than a pair of glasses, or a cataract extraction at a later date.

Discussion—Dr. P. T. Grant, Grand Rapids; Dr. H. H. Sanderson, Detroit.

3. "Retinal Lesions Encountered in Cardiovascular Disease"—Dr. George F. Suker, Chicago.

Discussion—Dr. George Slocum, Ann Arbor; Dr. Don M. Campbell, Detroit.

4. "Heterophoria"—Dr. Albert S. Barr, Ann Arbor.

Discussion: Dr. Herbert T. White, Flint, Dr. Raymond J. Sisson, Detroit.

5. Case Reports: "Tenonitis." "Dislocated Lenses." "Foreign Body in the Orbit." "Unilateral Spasm of the Accommodation"—Dr. Alexander R. McKinney, Saginaw.

1. Spontaneous extrusion of a foreign body (piece of cartridge shell), which had passed entirely through globe, lodging in the orbit.

2. Persistent dilatation of the pupil which was finally explained by discovering a very small foreign body in the globe. Extraction with magnet and recovery.

3. Dislocation of hypermature cataractous lens in the vitreous necessitating enucleation.

4. Dislocation of lens into anterior chamber in a high myope. Liquid vitreous. Extraction and recovery.

5. Suppurative Tenonitis, metastatic in origin. Staphylococcus albus. Enucleation with gold ball implant.

Discussion—Dr. R. D. Sleight, Battle Creek; Dr. Wm. Edw. McGarvey, Jackson.

Wednesday, September 14, Dr. Suker will present a reel of Motion Pictures of a new Operation for Glaucoma which in his hands "has been very satisfactory in every detail."

Thursday, September 15, Dr. Lillie will show before our Section a four hundred foot reel of "Cataract Surgery in India" pictures, which he will describe.

LUNCHEON—12:00 M.

Round Table Conference: Dr. George F. Suker, Chicago.

"Ophthalmological Problems of Everyday Practise."

"A New Operation for Glaucoma"—Motion pictures.

QUESTIONS DESIRED DISCUSSED MUST BE WRITTEN AND HANDED IN EARLY FOR DR. SUKER'S CONSIDERATION.

Thursday, September 15—9:30 A. M.

1. Case Presentations and Reports—Dr. Ralph B. Fast, Kalamazoo.

2. "The Differential Diagnosis of Sinus Disease"—Dr. Millard F. Arbuckle, St. Louis, Missouri. Lantern slides.

Discussion—Dr. H. Lee Simpson, Detroit; Dr. Robt. Frazer, Battle Creek.

3. "The Clinical Significance of Retrobulbar Neuritis"—Dr. W. I. Lillie, Rochester, Minnesota. Lantern slides.

Retrobulbar neuritis is a definitely established clinical entity, although the etiology is not always so readily revealed. Any case of retrobulbar neuritis is important enough to warrant a thorough search for any or all causes, inasmuch as it may be a prodromal phase of a serious ailment.

Retrobulbar neuritis may be either acute or chronic, depending upon the case. The chronic type is more readily overlooked both by the patient and the doctor, and is not so amenable to treatment. A large number of the acute type spontaneously get better, and one is apt to credit whatever form of treatment instigated as the curative agent.

The etiology of retrobulbar neuritis as revealed at the Mayo Clinic, and representative case histories of each group, are presented. The type of treatment and the end-results obtained in the different groups are summarized.

Discussion—Dr. Robert G. Laird, Grand Rapids; Dr. John R. Rogers, Grand Rapids.

4. "Certain Rhinologic Aspects of Allergy"—Dr. Warren T. Vaughan, Richmond, Virginia. Lantern slides.

Discussion—Dr. George L. Waldbott, Detroit; Dr. Ferris N. Smith, Grand Rapids.

LUNCHEON—12:00 M.

Round Table Conference: Dr. Millard F. Arbuckle, St. Louis, Mo.

Dr. W. I. Lillie, Rochester, Minn.

"Eye, Ear, Nose and Throat Problems of Everyday Practise."

"Cataract Surgery in India." Motion pictures.

QUESTIONS DESIRED DISCUSSED MUST BE WRITTEN AND HANDED IN EARLY FOR DR. ARBUCKLE'S AND DR. LILLIE'S CONSIDERATION.

Dermatology and Syphilology

Chairman: C. K. VALADE, Detroit.

Secretary: G. H. BELOTE, Ann Arbor

Wednesday, September 14, 1932

9:15 A. M.

Election of Officers.

1. "The Treatment of Malignant and Pre-malignant Dermatoses"—Dr. C. K. Hasley, Detroit.

The various accepted methods of treatment of malignant skin lesions will be discussed. Emphasis will be placed on their response to X-Ray and Radium treatment in hypermassive doses. A portion of the paper will be devoted to the electrocoagulation method of treating malignancies which have received insufficient radiation therapy by underdosage over prolonged intervals of time. The paper will be illustrated with lantern slides.

2. "A Review of the Treatment of Psoriasis by the Low Nitrogenous Diet."—Dr. R. C. Jamieson, Detroit.

A brief mention of the early studies regarding diet in psoriasis, particularly a low nitrogenous intake. The effect of a low nitrogenous diet alone or in combination with other methods of treatment upon the lesions of psoriasis. Results reported. Relation of nitrogen intake to endocrine metabolism—particularly the pituitary. A brief discussion of whether an abnormal nitrogen intake can be only one of the many factors inducing a metabolic change resulting in psoriasis.

3. "The Management of the Treatment of Syphilis in General Practice"—Dr. George Van Rhee, Detroit.

Outline.

1. Introduction.
2. Drugs.
3. Dosage.
4. Patient.
 - A. Preparation.
 - a. Mental.
 - b. Economics.
 - c. Physical.
5. Scheme for Treatment.
 - A. Primary-Secondary.
 - B. Latent.
 - C. Prenatal.
 - D. Congenital.
4. "The Physical Therapy of the Commoner Skin Diseases"—Dr. H. J. Parkhurst, Toledo

The forms of physical therapy of the com-

moner dermatoses, as usually employed by the general practitioner, will be mentioned and evaluated, and statistics from the author's practice will be cited in an attempt to point out the most successful and practical procedure for the treatment of each skin disease.

Wednesday P. M.

Combined meeting of sections.

Thursday, September 15—9:30 A. M.

Presentation and Discussion of a group of Dermatologic cases at the Health Service of the Western State Teachers College. Discussants will attempt to establish diagnoses and point out the most successful forms of therapy.

Clinic in charge of Doctors A. E. West, A. P. Biddle, U. J. Wile, R. C. Jamieson, C. K. Valade, H. L. Keim, H. S. Bartholomew, and Arthur Woodburne.

HOUSE OF DELEGATES

Speaker: Henry J. Pyle, M.D., Grand Rapids.

Vice-Speaker: C. E. Dutchess, M.D., Detroit.

Secretary: F. C. Warnshuis, M.D., Grand Rapids.

First Session

Tuesday, September 13, 1932, 10:00 A. M.

1. Call to Order.
2. Report of Credential Committee.
3. Roll Call.
4. Speaker's Address.
5. President's Address.
6. President-Elect's Address.
7. Council's Annual Report.
8. Appointment of Reference Committees.
 - (a) Council.
 - (b) Society Affairs.
 - (c) Miscellaneous Business.
9. Election of Nominating Committee.
 - (a) To Nominate:
 1. Three Delegates to A.M.A.
 2. Three Alternate Delegates A.M.A.
 3. Place for Annual Meeting.
10. Committee Reports.
 1. Civic and Industrial Relations.
 2. Legislative.
 3. Woman's Auxiliary.

4. Survey of Health Agencies.
5. Radio Committee.
6. Delegates to A.M.A.
11. New Business and Resolutions.
12. Adjournment.

Second Session

2:45 P. M.

1. Call to Order.
2. Report of Credential Committee.
3. Roll Call.
4. Reference Committee Reports.
 - (a) Council.
 - (b) Society Affairs.
 - (c) Miscellaneous Business.
5. Unfinished Business.

AMENDMENT TO CONSTITUTION

ARTICLE III, SECTION I:

In second line, after honorary members, insert the words "Member Emeritus" and add the following new section as Section 6, Article III:

"Section 6: Emeritus Members: Any member in good standing and good repute who has maintained an active county society affiliation for twenty-five years and has attained the age of 70 shall automatically become a member emeritus. Members Emeritus shall hold all the privileges of membership, including the Journal, and shall be relieved of paying the annual dues of this society."

6. New Business and Resolutions.
7. Adjournment.

Third Session

7:45 P. M.

1. Report of Credential Committee.
2. Roll Call.
3. Final Report of Reference Committees.
4. Elections.
 - (a) President-Elect.
 - (b) Report of Nominating Committee.
 1. Three A. M. A. Delegates—Terms Expiring: C. S. Gorsline, H. A. Luce, J. D. Brook.
 2. Three A. M. A. Alternate Delegates—Terms Expiring: C. F. Moll, Henry E. Perry, R. H. Denham.
 - (c) Election of Councilor
 - 7th District: T. F. Heavenrich—Term Expired.
 - 8th District: Julius F. Powers—Term Expired.

9th District: Harlan MacMullen—Term Expired.

10th District: Paul R. Urmoston—Term Expired.

- (d) Place for Annual Session.
- (e) Speaker.
- (f) Vice-Speaker.

5. Unfinished Business.

COMMITTEE ON CREDENTIALS

A. A. McNABB, Chairman
C. E. HALSEY
E. J. WITT
A. T. HAFFORD
T. P. TREYNOR

All delegates must obtain approval of their credentials before being seated. The Committee will convene at 9:00 A. M., September 13, at the Presbyterian Church House.

DELEGATES TO ANNUAL MEETING, KALAMAZOO, MICHIGAN*¹

September 13-15, 1932

Alpena County—15

E. L. FOLEY
L. F. Secrist

Barry—12

C. P. LATHROP
H. A. Adrounie

Bay-Arenac-Iosco—61

F. S. BAIRD
L. Fernald Foster

Berrien—38

E. J. WITT
R. E. Reagan

Branch—12

A. G. HOLBROOK
R. L. Wade

Calhoun—105

C. S. GORSLINE
A. T. HAFFORD
W. L. Godfrey
A. D. Sharp

Cass—12

W. C. McCUTCHEON
S. L. Loupee

Chippewa-Mackinac—17

F. C. BANDY
E. H. Webster

Clinton—12

W. B. McWILLIAMS
A. O. Hart

*Delegates names appear in capital letters; alternates in small letters.

¹Numbers opposite County names indicate paid membership.

Delta—23

J. W. TOWEY
A. H. Miller

Dickinson-Iron—19**Eaton—18**

A. G. SHEETS
K. A. Anderson

Genesee—129

FRANK REEDER
GEORGE CURRY
JACK CONNELL
H. Randall
D. Wright
M. Burnell

Gogebic—24

W. E. TEW
A. J. O'Brien

Grand Traverse-Leelanau—28

E. F. SLADEK
F. B. Minor

Gratiot-Isabella-Clare—28

T. J. CARNEY
W. L. Harrigan

Hillsdale—19

BURT F. GREEN
A. E. Martin

Houghton—40

W. A. MANTHEI
Alfred La Bine

Huron—6**Ingham—68**

K. B. BRUCKER
L. G. CHRISTIAN
Milton Shaw
C. F. De Vries

Ionia-Montcalm—33

W. W. NORRIS
A. J. Bower

Jackson—64

PHILIP RILEY
J. J. O'MEARA
G. S. Clarke
H. A. Brown

Kalamazoo—122

F. T. ANDREWS
A. A. McNABB
D. C. Rockwell
J. T. Itzen

Kent—205

G. H. SOUTHWICK
J. D. BROOK
A. V. WENGER
W. E. WILSON
R. H. DENHAM
A. M. Moll
E. N. Nesbitt
W. A. Hyland
E. W. Schnoor
C. F. Snapp

Lapeer—16

H. M. BEST
W. A. Gift

Lenawee—34

C. H. WESTGATE
E. C. Raabe

Livingston—12**Luce—10**

H. E. PERRY
E. H. Campbell

Macomb—32

J. N. SCHER
G. F. Moore

Manistee—13

A. A. McKAY
C. L. Grant

Marquette-Alger—36

V. H. VANDEVENTER
L. W. Howe

Mason—8

L. W. SWITZER
E. G. Gray

Mecosta—19

THOS. P. TREYNOR
Leo Chess

Menominee—10

M. E. CHAMPION
S. C. Mason

Midland—8

C. V. HIGH, SR.
R. E. Rice

Monroe—29

P. D. Amadon

Muskegon—66

F. W. GARBER, SR.
C. J. Bloom

Newaygo—10

A. C. TOMPSETT
H. R. Moore

Northern Michigan—29

WESLEY MAST
F. Riffenberg

Oakland—78

C. T. EKELUND
F. A. MERCER
B. M. Mitchell
L. A. Farnham

Oceana—8

A. R. HAYTON
J. H. Nicholson

Otsego-Montmorency,Crawford-Oscoda-**Roscommon-Ogemaw—11**

CLAUDE R. KEYPORT
C. G. Clippert

Ontonagon—5

E. J. EVANS
F. W. McHugh

Ottawa—28

A. E. STICKLEY
R. H. Nichols

Saginaw—75

A. E. LEITCH
R. M. Kempton

Sanilac—10

J. C. WEBSTER
R. K. Hart

Schoolcraft—5

DONALD ROSS
Valorus F. Lang

Shiawassee—27

I. W. GREENE

St. Clair—41

A. L. CALLERY
T. E. DeGurse

St. Joseph—17

R. A. SPRINGER
J. V. Blood

Tri—22

J. F. GRUBER
W. Joe Smith

Tuscola—24

O. G. JOHNSON
G. H. Kaven

Washtenaw—119

JOHN WESSINGER
THERON LANGFORD
George Muehlig

Wayne—1196

H. W. PLAGGEMEYER
L. J. HIRSCHMAN
FRANK A. KELLY
H. W. YATES
A. H. WHITTAKER
WM. J. STAPLETON, JR.
J. H. ANDRIES
H. A. LUCE
G. C. PENBERTHY
RICHARD McKEAN
C. E. DUTCHESS
L. O. GEIB
E. D. SPALDING
A. P. BIDDLE
J. L. CHESTER
B. U. ESTABROOK
C. E. HASLEY
WM. S. REVENO
J. D. CURTIS
D. P. FOSTER
N. M. ALLEN
S. P. L'ESPERANCE
STANLEY INSLEY
E. C. BAUMGARTEN
C. S. KENNEDY
A. E. Catherwood
L. T. Henderson
C. B. Lakoff
D. I. Sugar

Charles Barone

D. J. Leithauser

L. J. Gariepy

Wm. Woodworth

Basil L. Connelly

W. D. Barrett

R. D. McClure

L. Byron Ashley

Walter Hackett

J. C. Kenning

J. R. Rupp

Robert B. Kennedy

C. R. Davis

S. G. Meyers

X. A. Jones

Wm. H. Honor

L. Mae James

Frank Witter

V. L. Van Duzen

E. E. Poos

G. J. Baker

COMMITTEE REPORTS**SURVEY OF MEDICAL SERVICES AND HEALTH AGENCIES**

In accordance with instructions received from the House of Delegates at the special meeting held at Jackson, your committee has actively undertaken the task of surveying the medical facilities of Michigan. Several meetings of the committee were held and plans for the survey were adopted. Dr. Nathan Sinai, of Ann Arbor, was engaged as Director of Study.

The scope of the survey was fully outlined in the May number of the Journal of the Michigan State Medical Society. Perusal of the study plan will convince you of the magnitude of the task which we have undertaken. Considerable delay in sending out the questionnaires was occasioned by the fact that we had no adequate list of the physicians in active practice. The most recent directory of the A. M. A. was found to be very defective. Hence it became necessary for each county society to appoint a Public Relations Committee to report, as accurately as possible, the physicians in practice. Some of the counties responded very promptly while others have been more delinquent. This work is very difficult in the larger counties, especially Wayne. As soon as the county societies submitted these lists, the questionnaires were sent out. The response has been gratifying and approximately sixty per cent of the doctors in these counties have mailed their schedules.

As the work progressed, it seemed advisable to appoint sub-committees, to report on matters of unusual importance. The following sub-committees are at work:

Crippled Children: Carl E. Badgley, Detroit; G. Curry, Flint.

Child Health: David J. Levy, Detroit; L. Jones, Flint; R. M. Kempton, Saginaw.

Hospitals: E. T. Olsen, Detroit; W. L. Babcock, Detroit; J. T. Hamilton, Detroit.

Industrial: Earl I. Carr, Lansing; T. F. Heavenrich, Port Huron; Grover C. Penberthy, Detroit.

Laboratories: W. M. German, Grand Rapids; N. Larkum, Lansing.

Medical Problems of Colored Population: S. H. C. Owen, Detroit; H. E. Sims, Detroit.

Public Health: I. O. Geib, Detroit; C. A. Neafie, Pontiac.

State Mental Hospitals: O. R. Yoder, Ypsilanti; F. P. Currier, Grand Rapids.

Tuberculosis: H. D. Chadwick, Detroit; W. H. Winchester, Flint.

University Hospital: H. W. Plaggemeyer, Detroit; J. G. R. Manwaring, Flint; J. B. Jackson, Kalamazoo.

Cancer Problems: M. Ballin, Detroit; C. Weller, Ann Arbor.

Venereal Disease Problems: U. Wile, Ann Arbor; R. C. Jamieson, Detroit.

Following the collection and analysis of the special data, these committees will be asked to interpret the results and make recommendations. The final recommendations of your committee will therefore be based, not only upon its own judgment, but upon the judgments of many committees intimately acquainted with special problems in medical service.

The hospital and industrial committees are now reviewing the programs for study in these fields and collection of data will be started very soon. Your committee has been fortunate in obtaining the hearty coöperation of the Michigan Manufacturers Association. This association will distribute the schedules to Michigan manufacturers and will make the necessary arrangements for field studies wherever indicated.

A study of the economic statutes of the population in Michigan is now being made and it is planned to add whatever material is available on the cost of living.

While it is too early to make a definite determination, the income study will be attempted on a county-by-county basis. If data are not available on this basis, then the study will be made by trade areas in Michigan. It is felt that this study will be basic to the final conclusions.

The analysis of the material from the public health study is now being made. It is proposed in this study to show the organic structure of public health in Michigan, as well as its functioning, results, and costs. As a corollary to this study, much data will be secured

to show the activities and costs of medical welfare service.

At the end of the mailing program, a list of physicians who have not made returns will be sent to the public relations committee of each county and they will be asked to estimate the gross incomes, within broad limits, of the physicians who have failed to fill out the schedule. In this way, we shall be able to check the validity of the final figures to determine whether those who failed to make a return are spread more or less evenly throughout the entire group, or are to be found concentrated in one or two income categories.

Your chairman, as well as some members of the committee, has addressed several county societies on the subject of medical economics. The round table discussions at such meetings have demonstrated the interest which our members are showing in this survey. The opinions expressed will be useful in guiding us towards our final conclusions. Your chairman has attended the meetings of the Council and of its Executive Committee during the year in order to keep them acquainted with our progress.

There is an enormous amount of work yet to be done in the compilation of informative facts. We have endeavored to consider every factor related to health or medical care. If we have overlooked anything which you deem to be important, we shall welcome your suggestions. We believe that we have undertaken the most comprehensive survey that has ever been conducted by a state medical society. It is hoped that we will have a background that will give us an accurate picture of medical conditions in Michigan. We are proceeding "without haste and without rest," and ask for your patience and coöperation. We believe that the final report will be completed and published before the annual meeting in 1933.

Respectfully submitted,

W. H. MARSHALL.

CIVIC AND INDUSTRIAL RELATIONS COMMITTEE

The Civic and Industrial Relations Committee held two meetings, one at the Book-Cadillac Hotel in Detroit, December 11, 1931, and one at the Hayes Hotel in Jackson, January 27, 1932.

At the Detroit meeting, the committee passed a resolution as follows: "On every sick and accident claim proof that is made out by a physician, the physician should bill the insurance company involved for \$2.00, as per resolutions adopted in Jackson, September, 1929." This action was taken in order to

emphasize the meaning of the original resolutions and to protect the interests of Michigan physicians until the Bureau of Medical Economics of the American Medical Association makes its report. It is recommended that physicians adhere to the meaning of the resolutions by appending a statement for \$2.00 for services to each report blank filled out, whether it is requested by the claimant or the insurance company.

At the special meeting of the House of Delegates in Jackson on January 27, Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, outlined the progress of the national study of health and accident insurance companies. He stated that, "According to information received from the State Commissioners of Insurance, there appears to be no statute in the insurance department regulation in any state requiring that physicians shall furnish specific information for such claim proofs. Many of the statutes do provide that there shall be due proof of loss, but the interpretation of due proof of loss is left largely to the insurance companies."

Through Dr. Leland's activities, a special committee has been appointed by the International Claim Association, with Mr. Robert K. Metcalf, Manager of the Claim Department of the Connecticut General Life Insurance Company, as chairman. A preliminary report of the Bureau of Medical Economics appears in the Journal of the American Medical Association, April 2, 1932, on page 1171, entitled "Health and Accident Claim Proofs." It is recommended that every member of the Michigan State Medical Society read this report. In a communication from Dr. Leland, May 18, 1932, he promised that a subsequent report would be made on this very important question.

During the year, your chairman has had several conferences with physicians concerning the insurance question, and has carried on considerable correspondence with various insurance companies regarding disputes, which have arisen as a result of the resolutions.

The committee believes that one of the major problems, which greatly affects hospitals, physicians and the public, is the matter of medical care of highway accidents. Preliminary study on this question was begun two years ago, but inasmuch as the Michigan State Hospital Association appointed a committee for study, it was deemed advisable that the medical profession refrain from entering into this activity. As yet, no definite report has come from the hospital association and your committee recommends that this question be

made one of the major functions of the committee during the coming year.

Respectfully submitted,

HARRISON S. COLLISI, M.D., Chairman.

LEGISLATIVE COMMITTEE

The Legislative Committee of the State Medical Society met formally and informally during the year to study the history and present effects of regulations for those treating the sick. We reviewed the laws of many states and we studied the present and future needs for Michigan.

There were many guests at our meetings. There were many conferences with leaders in the professions, with officials in State Government administration, with Legislators and others. The committee acknowledges the great and helpful advice and counsel thus obtained.

The Special Session of the Michigan Legislature gave us opportunity this year for many contacts and especially it was possible for the Special Legislative Commission, created by a Concurrent Resolution, to meet and work. A series of hearings were held by this commission to which representatives of various groups were invited. The chairman of our committee was invited to one of these hearings. He responded and attended in company with two of the committee and five others named by the chairman of the Executive Committee of the Council.

Our position was presented in part by the following:

"If everyone interested or concerned with Medical Practice Acts was continuously mindful that they exist solely for the protection of the public, controversy would cease.

"A Supreme Court opinion under Constitutionality of the Medical Practice Act, in Michigan Compiled Laws, 1929, reads, 'The contention that this Statute interferes with the right of a citizen when ill to employ anybody he chooses as his physician is not supported by authority or reason. The practice of medicine affects the public health and it is clearly within the police power of the State to provide that those dealing with disease shall be amply qualified so far as human experience and education may qualify them.'

"Anyone who attempts to alter or change or to direct opinion leading to a change in our Medical Practice Act, unless he is prompted by selfish motives, must consider only those changes which may better protect the public and not those which may benefit a few, a class or a group.

"Even in this day of general enlightenment, superstitions and great credulity persist in

matters of disease. More than eighty groups or cults are listed today and are taking advantage of these relics of ancient human characteristics. An unsubstantiable promise is often readily accepted and may supersede discouraging opinion offered from a qualified source. Acceptance of the former frequently adds to the distress or shortens life. Hence, there is reason and legal authority in designating qualifications and conduct of those who practice the Healing Art and offer medical advice. Solicitation, subsidy, division of fees and practicing under a false or assumed name have necessarily been made unlawful and subject to penalties for the protection of the public.

"Consideration of Michigan's Medical Practice Act entails the protection of approximately 5,000,000 persons and regulation of the qualifications and conduct of about 6,000 Doctors of Medicine, practicing in houses, offices and 242 hospitals. Without scientific medicine, would not the 50,000 annual death rate and the 100,000 annually reported communicable diseases in Michigan be greater? With better regulation of medical practice would not these figures be reduced?

"Young men are expending annually about \$1,000,000.00 as their personal expenditures in obtaining medical, scientific education in the two medical schools of Michigan and are steadily confined in preparation until they are 25 to 30 years of age, which is half of this generation's average longevity, that is, 56."

Attention was called to many of the occurrences and experiences relating to the Medical Practice Act in Michigan. We continued, "Heretofore political pressure has quite generally activated many legislatures until 1931 when you saw the obligation of impartial initiation of action and created this, your Special Legislative Commission."

We proffered our aid and all resources of the medical profession.

It is our belief that the Special Commission for the Legislature understands the seriousness of their obligation and knows that medical practice acts are for the protection of the public, made credulous by illness, and not for political exchange or patronage.

The results of these activities cannot be measured or estimated until the next and future legislatures meet and act and the job continues.

Signed,

EARL I. CARR, Chairman.
GROVER C. PENBERTHY.
WM. C. McCUTCHEON.
A. M. HUME.
WM. HYLAND.

RADIO COMMITTEE

The Committee appointed by The House of Delegates met and furnished the various county societies with the following talks:

Some High Spots in Fifty Years of Medical Progress.
Colds and Their Complications.
How Are You?
The Old Medicine Chest.
A Romance of Vaccination.
The Way of the Vegetarian.
The Nature of Cancer.
The Hygiene of the Heart.
Smith in Search of Health.
Appendicitis.
Dangers of Sunlight and Ultra Violet Rays.
Improving the Complexion.
Diphtheria.
Toxoid.
Little Glands with Big Jobs.
Do Your Feet Hurt?
This Matter of Reducing.
Shingles.
Gall Bladder Disease.

Later, this list was added to with the following so that there was material for a weekly talk through the month of June:

Have You a Family Doctor?
Active Exercise Versus Mechanical Vibration.
Convulsions in Infancy and Childhood.
The Reason for Periodic Health Examinations.
What's the Matter with My Nose and Throat?
Teaching Children to Like Wholesome Foods.

Besides the above list numerous other radio talks were given on special occasions by physicians.

Following are the individual reports of the local county medical societies. Benton Harbor was not heard from:

BAY COUNTY MEDICAL SOCIETY

"Through the generosity of the owner, the Hon. James E. Davidson, and Manager Stanley Northcott, we were accorded fifteen minutes a week, for broadcasting over WBCM.

"For the first two and a half months, the time allotted was alternated weekly, from 10:10 to 10:15 A. M. to an evening time of 7:15 to 7:30.

"Talks were given weekly, from January 6 to June 8, a total of 22 broadcasts. These were given by 15 different members of this Society.

"While I know of no one having received any 'fan mail,' there were many favorable comments made by patients to their physicians.

"The project was very well received and the station authorities were very generous to the Society, in according the station's privileges."

L. F. FOSTER, M.D., Secretary.

GENESEE COUNTY MEDICAL SOCIETY

"The only radio talks given were a series of six sponsored by the Genesee County Tuberculosis Society.

"These broadcasts began Thursday, May 5, and ended Thursday, June 9, one being given each week. They were given by members of the local medical society, who talked from six to ten minutes at 7:00 P. M. The subjects were different phases of

the testing of school children, during the Society's campaign towards having all school children taken to their family physician for the Von-Pirquet test for tuberculosis."

C. W. COLWELL, M.D., Secretary.

JACKSON COUNTY MEDICAL SOCIETY

"We began broadcasting health talks over our local station, WIBM, on February 9, 1932. Since that time we have been on the air each Tuesday morning at 10:45 for fifteen minutes. To date we have given nineteen talks. The doctor's name who reads the talk is not announced. This has given rise to some objections on the part of the public as it likes to know who is speaking. However, we have adhered to this policy for fear of creating ill feeling within the Society, to do otherwise. We invite the public to send in subjects which they would like to hear discussed. These, of course, must be of general interest. We have had more requests than we have been able to fill.

"For subject material we have been using the material sent by the State Committee on Radio Education and some sent by Dr. Bauer of the American Medical Association. As the requests have come in we have had to prepare special articles to cover these. I have asked local men to prepare these and submit them to a committee before they were read.

"The local manager is well pleased with the interest shown in our programs and we will continue to be on the air as long as the people want it."

R. H. ALTER, M.D., Secretary.

KENT COUNTY MEDICAL SOCIETY

"Beginning February 25, there has been a broadcast by members of the County Medical Society over WOOD every Thursday at 3:00 P. M. These have included those talks sent out by the state committee, except in April, when there were three talks on Tuberculosis.

"We feel that due to our inability to obtain publicity in local newspapers, the hour of the broadcast, and probably the fact that WOOD programs are not unusually popular, our efforts have been largely wasted. Members of the society have been quite willing to take their turns reading before the microphone.

"Beginning this week (June 21) the hour has been changed to 10:00 A. M., Thursday mornings."

DON B. CAMERON, M.D.
WILLIAM L. BETTISON, M.D.
LEE O. GRANT, M.D.
PAUL W. KNISKERN, M.D.
L. L. FERGUSON, M.D.
Public Health Education
Committee.

WAYNE COUNTY MEDICAL SOCIETY

One hundred thirty-seven radio talks and question-and-answer broadcasts have been presented under the auspices of the Public Education Committee of the Wayne County Medical Society since the creation of the Sub-Committee on Radio, April 1, 1931. The Public Education Committee, under the chairmanship of Dr. Wm. J. Stapleton, Jr., has had a very active thirteen months, resulting in the attainment of definite goals. The Radio Division, under the guidance of Dr. F. H. Cole, Chairman; Drs. W. A. Chipman, M. C. Harvey, W. E. Keane and C. C. McClelland, has surprised the Society with the success it has achieved in its pioneering endeavors.

The Public Education Committee extends thanks to the many cooperating physicians and surgeons for their active help in preparing radio papers and in visiting radio stations at designated hours, which in many cases were not the most convenient for doctors. Such unselfish work has been appreciated not alone by the officers of the Wayne County Medical Society but by the public as well, to judge by its interest and response through the correspondence and over the telephone. The Committee intends to maintain its advantage and to assume full activity in its radio work with the autumn season. During the summer months only a few broadcasts of seasonal importance will be sponsored.

The Committee, and The Council of the Wayne County Medical Society, have entered a vote of thanks on their minutes to Station WWJ and to Station WEXL for their active support of the Society in its program of informing the public via the powerful medium of the radio. The health benefits derived by our people as a result of this cooperative endeavor between the radio stations and the Medical Society are immeasurable. The Society appreciates the altruism of its radio friends in donating so many generous minutes in the interests of better public health.

The lectures and talks since the last published list (on January 5, 1932) were:

Date	Name	Subject	Radio Station
January 5.....	Dr. Wm. J. Stapleton, Jr.....	"Fifty Years of Medical Progress".....	WEXL
January 7.....	Dr. Don Gudakunst.....	"Health of the School Child".....	WEXL
January 12.....	Dr. H. S. Berman.....	"Recurrent Coughs in Children".....	WEXL
January 14.....	Dr. A. R. Bauer.....	"The School Child".....	WEXL
January 19.....	Dr. C. K. Hasley.....	"What Everyone Should Know About Cancer".....	WEXL
January 19.....	Dr. Hugo Freund.....	"Truth and Fiction About Blood Pressure".....	WWJ
January 21.....	Dr. S. K. Beigler.....	"History and Treatment of Infections".....	WEXL
January 26.....	Dr. Ray Hughes.....	"The Nose and Its Neighbors".....	WEXL
January 26.....	Wm. J. Burns.....	"Why a Medical Society?".....	WWJ
January 29.....	Dr. Hayden Palmer.....	"Sinus Disease".....	WEXL
February 2.....	Dr. B. F. Glowacki.....	"The Ear".....	WEXL
February 2.....	Dr. A. S. DeWitt.....	"Heart Burden and Heart Consciousness".....	WWJ
February 4.....	Dr. Don J. Barnes.....	"Nutrition".....	WEXL
February 5.....	Dr. Wm. J. Stapleton, Jr.....	"Music and Medicine".....	WEXL
February 9.....	Dr. Harold Clark.....	"Tonsillitis".....	WEXL
February 12.....	Dr. A. R. Hackett.....	"Sports in Relation to Health".....	WEXL
February 16.....	Dr. Stewart Hamilton.....	"Cost of Hospital Care".....	WWJ
February 18.....	Wm. J. Burns.....	"Why a Medical Society?".....	WEXL
February 23.....	Dr. S. S. Altshuler.....	"The Normal Diet".....	WEXL
February 23.....	Dr. H. Lee Simpson.....	"Are Our Colds the Result of Modern Heating?".....	WWJ
February 25.....	Dr. M. J. Brady.....	"The Growth and Care of the Baby".....	WEXL
February 26.....	Dr. Harry August.....	WEXL
March 1.....	Dr. W. S. O'Donnell.....	"The Necessity of a Balanced Diet in the Feeding of Children".....	WEXL
March 8.....	Dr. B. F. Glowacki.....	"Madam Curie".....	WEXL
March 10.....	Dr. Frank Perkin.....	"Diabetes Mellitus".....	WEXL
March 15.....	Dr. Dan P. Foster.....	"Glands of Internal Secretions".....	WEXL
March 18.....	Dr. Wm. Fowler.....	"Romance of Anesthesia".....	WEXL

March 22.....	Dr. H. D. Chadwick.....	"History of Tuberculosis and Its Prevention".....	WWJ
March 24.....	Dr. G. R. Barzyk.....	"General Talk on Course and Diagnosis of Tuberculosis".....	WEXL
March 29.....	Dr. Richard Morgan.....	"History and Cause of Tuberculosis".....	WEXL
April 1.....	Dr. S. E. Gould.....	"Hope for the Diabetic".....	WEXL
April 5.....	Dr. E. D. Spalding.....	"The Heart—Its Work and Its Handicaps".....	WEXL
April 5.....	Dr. Bruce Douglas.....	"Diagnosis of Tuberculosis in Children".....	WWJ
April 7.....	Dr. H. S. Willis.....	"Diagnosis and Reaction of Childhood Tuberculosis".....	WEXL
April 12.....	Dr. Frederic Schreiber.....	"Convulsions".....	WEXL
April 19.....	Dr. Morris Marks.....	"Radium Waters".....	WEXL
April 19.....	Dr. Martin Hoffman.....	"Nervousness: Every Day Problems".....	WWJ
April 21.....	Dr. Mont Wickham.....	"Kidney and Bladder Diseases".....	WEXL
April 26.....	Dr. Robert Berman.....	"Effect of Business on Attitudes".....	WEXL
April 29.....	Dr. Leo Bartemeier.....	"Heart Pains and Complications".....	WEXL
May 3.....	Dr. Harry Kirschbaum.....	"Post Natal Care".....	WEXL
May 3.....	Wm. J. Burns.....	"Our Daily Question Box".....	WWJ
May 5.....	Dr. A. H. Whittaker.....	"Accidents and Your Child".....	WEXL
May 12.....	Dr. E. D. MacKenzie.....	"Pneumonia".....	WEXL
May 13.....	Dr. David H. Fink.....	"Rheumatism".....	WEXL
May 17.....	Dr. Sam Levin.....	"Hay Fever, Asthma and Eczema in Children".....	WEXL
May 17.....	Dr. Douglas Donald.....	"Indigestion".....	WWJ
May 19.....	Dr. W. C. C. Cole.....	"Cultivation of the Child's Appetite".....	WEXL
May 20.....	Dr. Leo J. Croll.....	"The Proper Care of Your Eyes".....	WEXL
May 24.....	Wm. J. Burns.....	"Questions We Are Asked".....	WEXL
May 27.....	Dr. L. W. Shaffer.....	"Popular Misconceptions in Dermatology".....	WEXL
May 31.....	Dr. D. L. Drummond.....	"Chronic Arthritis".....	WEXL
June 2.....	Dr. Emil Rothman.....	"Overweight Due to Glandular Defects".....	WEXL
June 7.....	Dr. A. E. Schiller.....	"The Care of Your Skin".....	WEXL
June 9.....	Dr. E. S. Gurdjian.....	"Present Day Menace of Head Injury".....	WEXL
June 10.....	Dr. Claire L. Straith.....	"Plastic Surgery".....	WEXL
June 14.....	Dr. Stanley Insley.....	"Hay Fever".....	WEXL
June 14.....	Dr. Milo J. Brady.....	"The Growth and Care of the Baby".....	WWJ
June 16.....	Dr. Arthur Bloom.....	"X-Ray in Health and Disease".....	WEXL
June 17.....	Dr. W. E. Johnston.....	"Stomach Ache".....	WEXL
June 21.....	Dr. S. G. Meyers.....	"Liver Troubles—Real and Supposed".....	WEXL
June 21.....	Dr. Wm. Fowler.....	"Romance of Anesthesia".....	WWJ
June 23.....	Dr. B. L. Connelly.....	"Cancer".....	WEXL
June 24.....	Dr. Wm. J. Stapleton, Jr.....	"Cleanliness and Health".....	WEXL
June 28.....	Dr. L. J. Gariepy.....	"Appendicitis".....	WEXL
June 30.....	Dr. F. B. Peck.....	"Diabetes in Children".....	WEXL
July 5.....	Dr. Dan P. Foster.....	"Pseudo-Medical Superstitions".....	WWJ
July 12.....	Dr. L. O. Geib.....	"The Periodic Health Examination".....	WWJ
July 19.....	Dr. B. F. Glowacki.....	"What Everyone Should Know About the Eyes".....	WWJ

SECOND COUNCILLOR DISTRICT

To the members of the Council and House of Delegates of Michigan State Medical Society; this office submits the following report of the radio broadcasting activities of the second councillor district of the Michigan State Medical Society:

November, 1931, Governor Brucker was in conference with this office, and he informed us that he was deeply concerned and very much interested in the activities of the Michigan State Medical Society.

At this conference, the Governor communicated with the officials of the Michigan State College, and asked that communication be made with this office.

December, the director of the broadcasting station of the Michigan State College conferred with this office and a health education program was arranged which consisted of series of talks. These lectures were sponsored and given by various members of the medical profession of the second Councillor district, and were announced in the catalog of the Michigan State College as a part of the Education Extension Program.

This schedule contained a medical talk on Health Education beginning the second semester of the college year, each Thursday from 3:30 to 4:00 P. M. The first lecture was given by Dr. J. Earl McIntyre on the subject "Some High Spots in Fifty (50) years of Medical Progress" January 9. January 14, Dr. Harry B. Weinburgh talked on "Colds

and Their Complications." January 21, Dr. John G. Rulison talked on "That Matter of Reducing." Dr. Fred L. Seager talked on "The Way of the Vegetarian" on January 28. February 4, Dr. Fred J. Drolett talked on "The Old Medicine Chest." February 11, Dr. Charles P. Doyle talked on "How Are You?" (Periodic Health Examinations). February 18, Dr. Milton Shaw talked on "The War on Heart Disease." February 25, Dr. Dana M. Snell talked on "Dangers of Sunlight and Ultra Violet Rays." March 3, Dr. Frank C. Dunn talked on "The Role of Heredity in Old Age." March 10, Dr. Earl I. Carr talked on "Hernia." March 17, Dr. George F. Bauch talked on "Cancer." March 24, Dr. Karl B. Brucker, talked on "Diseases of the Rectum." April 7, Dr. Harry S. Bartholomew talked on "Poison Ivy." April 14, Dr. C. Ford De Vries, "Significance of Indigestion." April 21, Dr. Elmer G. McConnell, "Care of the Feet." April 28, Dr. Mathew S. Hurth, "Little Glands With Big Jobs." May 5, Dr. Wm. E. McNamara, "The Value of Keeping Employers in Good Health." May 12, Dr. Samuel Osborn, "Constipation." May 19, Dr. Horace L. French, "Contagious Diseases of Childhood." May 26, John F. Sander, M.D., "Immunization."

We closed our radio broadcasting talks on Health Education over Station WKAR at Michigan State College at the close of the college year May 26, 1932.

The reaction to our program was rather

spasmodic. Letters and telegrams from various parts of the State commending us on our work. However as a whole they seemed to be rather few in number and far between. Therefore, we were at a loss to know whether we were accomplishing a great deal of good.

However this office was very much surprised and greatly delighted when during the past week, the director of the broadcasting station WKAR at Michigan State College telephoned us saying that since the close of the college year and the discontinuation of our broadcasts that the inquiries concerning it and the requests for its continuance were constantly becoming more numerous, and that in his opinion the medical talks of the last semester were the most valuable and appreciated of their radio extension service, and asked that the Second Councillor District prepare and sponsor a weekly program for the entire college year over 1932 and 1933.

After some little difficulty and delay the Jackson Broadcasting Station was secured February 2 of this year and the members of the Jackson County Medical Society have been preparing for broadcasting a health education talk each Tuesday morning at 10:45 since that time.

At first the manager was reluctant to donate the time. It was thought this was due to a large part to a fear that the medical men might use it as an advertising medium and criticize other forms of treatment. The operators of which were paying him good money for their time on the air.

However, after a few programs, the manager became very enthusiastic and has promised the use of the station as long as we wish to use it, so long of course the same class of education programs are conducted.

Jackson has been inviting their listeners to mail in subjects which they would like to hear discussed. In this way, more requests are received than they are able to fill.

For subject matter, we have been using that prepared by the State Committee on Radio Broadcasting, some from the American Medical Association, some from the University of Michigan and a considerable number of original papers were prepared by our own members, which were submitted to our committee for censoring before it went upon the air.

In addition to using the above mentioned material, members of the Jackson County Medical Society have given original papers on the following subjects: Appendicitis, Toxoid, Cancer, Shingles, Tuberculosis, Gall Bladder Disease, Diphtheria, Periodic Health Examinations, Erysipelas and Tuberculin. The Jackson Station has observed that their listeners seem more interested in hearing some partic-

ular disease discussed than some general subject like "A Romance of Vaccination."

Most of the requests come from those who are ill and are interested in having their particular ailment discussed.

We also note that the most of our listeners are from the rural districts, or small villages and towns.

Another particular difference in the policy of the broadcasting stations at Michigan State College and Jackson is this: At Jackson the management prefer that no doctor's name be mentioned in broadcasting a talk. WKAR, the Michigan State College Station, refuses to allow a health talk to be broadcasted unless the Doctor talking is introduced by the director, whether he is presenting an original talk or whether some one is pinch-hitting and reading his paper for him. They insist upon the broadcaster being a bona fide medical man and his name announced. Inasmuch as we have the two stations in this district namely: Lansing and Jackson, so far the Ingham County Medical Society has done the entire broadcasting at Michigan State College and the Jackson County Medical Society broadcasting over the Jackson Station.

Hillsdale County having no station has been invited to prepare subjects and participate in both stations at Lansing and Jackson.

This office has found the medical men of this district very loyal and conscientious in giving their time and preparing and presenting their subjects each Thursday afternoon when assigned at Michigan State College and I believe the same condition exists on Tuesday morning in Jackson.

So far I have heard of no necessity for pinch-hitting.

The above report is respectfully submitted for your consideration.

(Signed).

J. EARL MCINTYRE, M.D.
Councillor, Second District.

ADVISORY COMMITTEE

To the House of Delegates:

The Advisory Committee of the Women's Auxiliary reports that there have been no meetings of this Board held this year.

We have had no request for aid or action from the Women's Auxiliary, therefore there has been no need for any meeting of this committee.

Due to the extremely capable handling of this organization by its president, Mrs. McIntyre, they have functioned in splendid style and are demonstrating that the Female of the Species are efficient.

The committee wishes to take this opportu-

nity to express appreciation, in behalf of the State Medical Society, for what this organization has accomplished.

Respectfully submitted,

THEO. F. HEAVENRICH, Chairman.

FRED C. WARNSHUIS.

LOUIS J. HIRSCHMAN.

COUNCIL

Chairman: B. R. Corbus, Grand Rapids.

Vice-Chairman: Henry Cook, Flint.

Secretary: F. C. Warnshuis.

SESSIONS

September 12, 1932—8:00 P. M.

Burdick Hotel

Subsequent sessions will be held at the call of the Chairman.

COUNCILOR DISTRICTS

First District.—Wayne.

Second District.—Hillsdale, Ingham, Jackson

Third District.—Brance, Calhoun, Eaton, St. Joseph

Fourth District.—Allegan-Kalamazoo-Van Buren, Berrien, Cass

Fifth District.—Barry, Ionia-Montcalm, Kent, Ottawa

Sixth District.—Clinton, Genesee, Shiawassee

Seventh District.—Huron, Lapeer, Sanilac, St. Clair

Eighth District.—Griatiot-Isabelle-Claire, Midland, Saginaw, Tuscola, and Cladwin unattached

Ninth District.—Grand Traverse-Leelanau, Manistee, Benzie, Tri (Kalkaska, Missaukee, Wexford)

Tenth District.—Bay-Arenac-Iosco, O. M. C. O. R. O. (Otsego, Montmorency, Crawford, Oscola, Roscomomon and Ogemaw combined)

Eleventh District.—Mason, Mecosta, Muskegon, Oceana, Newaygo, Osceola-Lake

Twelfth District.—Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Hought-Baraga-Keweenaw, Luce, Ontonagon, Marquette-Alger, Menominee, Schoolcraft

Thirteenth District.—Alpena-Alcona, Northern Michigan (including Antrim, Charlevoix, Cheboygan, Emmet, Presque Isle

Fourteenth District.—Livingston, Lenawee, Monroe, Washtenaw

Fifteenth District.—Macomb, Oakland

COUNCILORS

	Term Expires
HENRY R. CARSTENS.....1st DistrictA	Detroit1935
A. S. BRUNK.....1st DistrictB	Detroit1935
J. E. MCINTYRE.....2nd District	Lansing1935
GEORGE C. HAFFORD.....3rd District	Albion1935
C. E. BOYS.....4th District	Kalamazoo1936
B. R. CORBUS.....5th District	Grand Rapids.....1936
HENRY COOK.....6th District	Flint1936
T. F. HEAVENRICH.....7th District	Port Huron.....1932
JULIUS POWERS.....8th District	Saginaw1932
HARLAN MacMULLEN.....9th District	Manistee1932
PAUL R. URMSTON.....10th District	Bay City.....1932
GEORGE LeFEVRE.....11th District	Muskegon1933
RICHARD BURKE.....12th District	Palmer1933
B. H. VAN LEUVEN.....13th District	Petoskey1934
J. D. BRUCE.....14th District	Ann Arbor.....1934
C. A. NEAFIE.....15th District	Pontiac1935

Annual Program Woman's Auxiliary Michigan State Medical Society Kalamazoo

September 13-15, 1932

President: Mrs. J. Earl McIntyre, Lansing.

Secretary: Mrs. W. E. McNamara, Lansing.

Headquarters: Burdick Hotel.

Tuesday, September 13

Coöperative Dinner at Home of Mrs. R. A. Morter, Oakland Drive.

Wednesday, September 14

10:00 A.M. President's Conference.

1:00 P.M. Luncheon—Kalamazoo Country Club.

Short Addresses:

Carl F. Moll, Flint, President State Medical Society.

J. Milton Robb, Detroit, President-Elect Michigan State Medical Society.

"Auxiliary Objectives and Opportunities," Frederick C. Warnshuis, Secretary, Michigan State Medical Society.

3:00 P.M. Annual Business Meeting.

Committee Reports.

Election of Officers.

Thursday, September 15

10:00 A.M. Visit to Parchment Paper Company.

2:00 P.M. Visit to Upjohn Pharmaceutical Company.

NOTE: Members and visiting ladies are requested to register at the Information Desk, Burdick Hotel.

Drives around the city are planned for members not attending other meetings.

General Arrangements Committee: Chairman, Mrs. R. A. Morter, Mrs. John McGregor, Mrs. William Shackleton, Mrs. R. J. Hubbell, and Mrs. Walter den Bleyker.

OAKLAND COUNTY—PONTIAC, MICHIGAN

President.....Mrs. Robert H. Baker, 57 Cherokee

Vice President

Mrs. Palmer E. Sutton, 1138 York, Huntington Woods

Secretary-Treasurer.....Mrs. Hubert M. Heitsch, 549 Perry St.

INGHAM COUNTY—LANSING, MICHIGAN

President.....Mrs. H. S. Bartholomew, 902 W. Michigan Ave.

Vice President.....Mrs. P. C. Strauss, 1518 W. Michigan Ave.

Sec'y-Treas.....Mrs. T. P. Vander Zalm, 112 S. Jenison Ave.

JACKSON COUNTY—JACKSON, MICHIGAN

President.....Mrs. George Seybold

Vice President.....Mrs. Walter Finton

Secretary.....Mrs. Miar McGoffin

Treasurer.....Mrs. Ennis Corley, 1009 Third St



MRS. J. EARL MCINTYRE
President Women's
Auxiliary



MRS. W. E. McNAMARA
Secretary Women's
Auxiliary



DR. CAROLINE BARTLETT
CRANE
Auxiliary Director

SAGINAW COUNTY—SAGINAW, MICHIGAN

President.....Mrs. S. A. Sheldon, 2 Holland Court
Secretary.....Mrs. D. H. Swengel, 901 Emerson St.
Treasurer.....Mrs. W. K. Slack, 5 Jefferson Court

BAY CITY COUNTY—BAY CITY, MICHIGAN

President.....Mrs. C. A. Stewart
First Vice President.....Mrs. H. P. Lawrence
Second Vice President.....Mrs. E. A. Wittner
Secretary.....Mrs. Ray Perkins
Treasurer.....Mrs. H. M. Gale, 517 N. Van Buren St.
Corresponding Secretary.....Mrs. Charles M. Swantek

KALAMAZOO—KALAMAZOO, MICHIGAN

President.....Mrs. Walter Den Bleyker, 513 S. Burdick St.
First Vice President.....Mrs. W. O. Jennings, 442 Stuart Ave.
Second Vice President.....Mrs. I. W. Brown, 2335 S. Rose St.
Secretary-Treasurer.....Mrs. Frederick M. Doyle, 1219 Maple St.

CALHOUN COUNTY—BATTLE CREEK

President.....Mrs. R. C. Stone, 120 Garrison Ave.
First Vice President.....Mrs. M. J. Capron, 102 Ann Ave.
Second Vice Pres.....Mrs. Theo. Kolvoord, 137 Frelinghuysen
Secretary.....Mrs. G. W. Brainard, 204 Chestnut
Treasurer.....Mrs. B. G. Holtom, 94 Central

WAYNE COUNTY—DETROIT, MICHIGAN

President.....Mrs. R. E. Loucks, 337 W. Grand Blvd.
Vice President.....Mrs. Claire Straith, 19305 Berkley Road
Recording Sec'y.....Mrs. Zina Bennett, 4909 Buckingham Ave.
Corresponding Sec'y.....Mrs. L. O. Geib, 3860 St. Clair Ave.
Treasurer.....Mrs. William Rieman, 7919 Kercheval Ave.
Custodian.....Mrs. L. T. Henderson, 713 University Place

The foregoing generalizes the program of the Sixth Annual Meeting of the Auxiliary. A cordial invitation is extended to every doctor's wife or daughter to attend this annual meeting whether a member or not.

The officers are very desirous to have you present, to learn what is being accomplished to arouse your interest with the hope that on returning home you will aid in furthering our plans in your own community.

While your "Doctor Man" is attending the meetings of the State Medical Society join the Auxiliary for profit, new friends and entertainment. You will be pleasantly pleased and you will value these new friendly contacts. We bid you a cordial welcome.

Be sure and register on arrival, receive a badge and join our congenial group.

MRS. J. EARL MCINTYRE,
President.

ENTERTAINMENT

1. Cards to Country Clubs may be secured at the registration desk.
2. Inquire at information booth for program of Auxiliary meetings.
3. Ladies will register and receive badge at Auxiliary headquarters in the Burdick Hotel.
4. Request "Parking Tag" for your car when you register.
5. Reserved seats for all wearing badges will be held till 7:40 p. m., in main section of the civic auditorium and high school auditorium.
6. The following local committees will be happy to aid you and make your stay pleasant:

LOCAL COMMITTEES—ANNUAL MEETING—KALAMAZOO

Entertainment

Dr. John MacGregor, Chairman

Registration

Dr. John Koestner, Chairman

Hotels

Dr. W. G. Hoebeke, Chairman

History

Dr. Ralph Shook, Chairman

Auxiliary

Dr. Sherman E. Andrews, Chairman

Finance

Dr. C. E. Bennett, Chairman

Garages and Parking Spaces

Dr. Kenneth Crawford, Chairman

Commercial Exhibits

Dr. Hugo Aach, Chairman

Scientific Exhibits

Dr. Hazel Prentice, Chairman

Medicine.....Dr. Stewart
 Surgery.....Dr. Shackelton
 Gynecology and Obstetrics.....Dr. Boys
 Dermatology.....Dr. West
 Ophthalmology and Otolaryngology
 Dr. Fast and Dr. Fulkerson
 Pediatrics.....Dr. Collins

COMMERCIAL AND SCIENTIFIC EXHIBITS

These will be found on the first floor of the Church House. Members are urged to plan to spend a few hours to visit these exhibits. Patronize these business firms by at least a visit to their booths.

Scientific:

Facial Reconstruction: Claire L. Straith, M.D.
 Pathology: James E. Davis, M.D.
 Biological: R. Kahn, Ph.D.
 Hip Tuberculosis: Vernon Hart, M.D.
 Congenital Tuberculosis: George Sewell, M.D.
 Thoracic Surgery: Wm. A. Hudson, M.D.
 Bronson Hospital:
 [And others]

Commercial:

Petrolagar Laboratories.
 Medical Protective Co.
 Professional Underwriters.
 S. M. A. Company.
 Kellogg Food Co.
 Mead-Johnson.
 Columbus Pharmacal Co.
 Gerber's Foods.
 Kuhlman Instruments and Supplies.
 G. A. Ingram Co., Surgical Supplies.
 Upjohn Pharmaceutical Co.
 Hacks Orthopedic Shoes.
 Kellogg Foundation.

NOTES

1. The Kalamazoo Academy will tender a buffet supper, Tuesday evening, 10:00 P. M., at the Kalamazoo Country Club.
2. Speakers have been provided for the Wednesday and Thursday Luncheon Clubs of Kalamazoo.
3. Section Chairmen will insist on strict observance of program placement. Papers will be presented at the time and in the order in which they are listed.

*The Kalamazoo Profession Bids You Welcome.
 You Are Urged to Accept Their Invitation*

THE JOURNAL

OF THE

Michigan State Medical Society

PUBLICATION COMMITTEE

J. D. BRUCE, M.D., Chairman.....Ann Arbor
A. S. BRUNK, M.D.....Detroit
B. H. VAN LEUVEN, M.D.....Potoskey

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2642 University Avenue, St. Paul, Minnesota, and
Grand Rapids, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to J. H. Dempster, M.D., 641 David Whitney Bldg., Detroit, Michigan.

Reprints of papers published will be furnished authors at cost if the order is placed at the time the galley proofs are returned to the editor. *The cost of illustrations is to be defrayed by the author of the paper whether reprints are ordered or not.*

Contributors are responsible for all statements, conclusions and methods in presenting their subjects. Their views may or may not be in agreement with those of the editor. The aim, however, is to allow authors as great latitude as the general policy of The Journal and the demands on its space may permit. The right to reduce in length or to reject any article is reserved. Articles are accepted for publication on condition that they are contributed solely to this Journal.

All communications regarding advertising and subscriptions should be addressed to F. C. Warnshuis, M.D., 2642 University Avenue, St. Paul, Minnesota, or Suite 1508 Grand Rapids National Bank Bldg., Grand Rapids, Michigan.

SEPTEMBER, 1932

"I hold every man a debtor to his profession, from the which as men of course do seek to receive countenance and profit, so ought they of duty to endeavor themselves, by way of amends, to be a help and ornament thereunto."

—Francis Bacon

EDITORIAL

112TH ANNUAL MEETING

In the August number of this Journal appeared the preliminary program of the 112th annual meeting of the Michigan State Medical Society to be held in Kalamazoo on September 13, 14 and 15. The complete program will be found in this number of the Journal. It will be seen that those having it in charge have put forth their best

effort to make this program equal if not better than those of former years. One of the ways in which as physicians we may meet the exigencies of the times is better prepara-



DR. CARL F. MOLL
President, Michigan State Medical Society

tion for the work before us. The annual meetings of the State Medical Society are virtually post-graduate courses in medicine, surgery and allied specialties. These papers presented will of course appear in future numbers of this Journal. The discussions, however, will not appear, so in order to get the reaction to the work of the various contributors it is necessary to be present to take part. The annual meetings of the Society afford an opportunity for personal contact with other members, which has an intangible though real social value.

Kalamazoo is easily accessible from all parts of the State. The local profession are putting forth every effort in the way of en-

tertainment of the visiting members of the Michigan State Medical Society. The best appreciation of the guest is to be present to partake of the hospitality of the host.



DR. J. M. ROBB
President-elect, Michigan State Medical Society
(Photo by Felix Portrait Studios)

A CIVIC DUTY

Perhaps there has never been a time when members of the medical profession should be more actively concerned with civic affairs than at present, not only so far as local politics are concerned, but state and national politics as well. It would take almost superhuman wisdom to advise in the matter of voting. However, there is no question but that the men who represent us in government should be of the highest character and vision. It has been said, and with a great deal of truth, that the present depression is largely the result of a moral breakdown, hence the way out rests in the ability and foresight of the people to select men who are strong enough to resist the pleas of organized minorities, even at the risk of sacrificing their chances of being returned to office.

The physicians of the United States possess advantages in the way of education and an independence which is born of the fact that each (true in the vast majority of in-

stances) is engaged in an individualistic calling.

There are many things in which the peculiar training of the physician is needed; perhaps the most important is the public health. No organized system of public health can function without one hundred per cent coöperation on the part of the medical profession and this refers particularly to those engaged in general practice. Not only this; there are also problems arising out of the practice of medicine itself. Then there are social and economic problems that call for the influence of men of standing and independence. We have referred frequently to the insidious inroads to state medicine. The practice of medicine by the state, however, is a remote probability when we consider the condition of state treasuries. The danger of socialization of medicine is not so remote. In fact, we have it wherever patients are encouraged to leave the independent practitioner for city clinics or where insurance companies seek to control industrial and other groups. We still feel that the interests of the public are best served when each person is privileged to consult the physician of his own selection and the peculiar personal relation of patient and physician is preserved.

LIVING DANGEROUSLY

From time to time there have appeared editorials in this Journal on the subject of malpractice, urging physicians to protect themselves by membership in the County Medical Society, which also entitles them to defense by the State Medical Society in the event of threatened suit. We have always realized, however, that those who are apt to read editorials are already protected and not in need of any advice along that line, but it seems impossible to reach those who do not consider membership in a medical society worth while. Every now and then cases come up in which doctors have allowed their membership in their county society to lapse and probably have later on resumed membership; but in the interval trouble has arisen. Those who are members of the Michigan State Medical Society might perform a very worthy service by urging any friends outside to join their County Medical Society, if nothing more than for the protection it affords. This, however, is only

one advantage of membership. There are also the professional advantages gained by contact with other members, as well as the opportunity to come in contact with the best medical thought.

We have also touched upon the matter of speaking disparagingly of the results of another doctor's treatment. A doctor's reputation is as much an asset though intangible as any material resource he may possess, and it therefore should not be injured by disparaging word or gesture.

The editing of a Journal such as this calls for a certain precautionary attitude which few recognize apart from the editor himself. We have had occasion to delete expressions and statements in contributed papers which, even though true, if published, would be liable to cause trouble. It is an expensive and uncertain matter to be called into court even to prove that one is right. In the matter of libel, discretion is the better part of valor. Brosnan, the Counsel for the Medical Society for the State of New York, writing in the New York State Journal of Medicine, quotes the libel law, which defines libel as, "A malicious publication, by writing, printing, picture, effigy, sign or otherwise than by mere speech, which exposes any living person, or the memory of any person deceased, to hatred, contempt, ridicule or obloquy, or which causes, or tends to cause, any person to be shunned or avoided, or which has a tendency to injure any person, corporation or association of persons, in his or their business or occupation is a libel."

This has been carried so far as to be construed to apply to biographies even of persons long dead, if their descendants felt it worth while to prosecute.

Another matter on which editors must be on their guard is that of violating copyright. If the writer of a paper, for instance, finds it advantageous to make a lengthy quotation, he will do well to write the publisher or author of the article for permission. This is usually granted. However, to quote at length without this permission is violating the law of copyright and one becomes amenable to the penalties of the law should the owner feel it expedient to prosecute. Copyright privileges cover twenty-eight years, so that in quoting from works published beyond this time, mere mention of the source of the material is sufficient. Recent books, however, are very particular in the matter and stipulate that no part of the book may

be quoted without the permission of the publisher. With this permission given it is customary to acknowledge it by a brief line to that effect.

THE WRITING OF MEDICAL PAPERS

No one realizes the danger of commenting on such a subject more than an editor, therefore no effort will be made towards an exhaustive discussion. Perhaps no other person appreciates the pitfalls of composition more than one whose duty it is to read more or less critically the work of others. This experience, however, should entitle one to a respectful hearing by the writer of medical papers.

Writing is a difficult task even for the professional, much more so for the occasional author. Perhaps there is no work which requires more constant study and practice, and the fact that the professional author confesses his difficulties in writing and revising should supply courage to us who appear in print at rare intervals. Oscar Wilde once said that he labored all one forenoon over the removal of a comma, and all the afternoon in reinserting it. The most readable prose is that which has been the object of the most painstaking effort. Sir Clifford Allbutt, whose writings rival those of Sir William Osler, referring to student essays, theses for medical degrees, says, "The student is apt to think that an easy style comes of letting himself go; and that a glaze can be put on by any tiresome pedant. He is unaware that an easy limpid style is the result of consummate craftsmanship." Sheridan has expressed the same idea in a more forceful though less elegant way, "Easy reading makes damned hard writing." Buffon, the naturalist, is said to have rewritten his prose twelve to fourteen times. He was accustomed to have it read to him so that he might note where the reader hesitated, which would indicate additional polishing and the rearranging of punctuation marks.

The writer of a medical paper should realize that style and matter are as intimately associated as flesh and bone. As Carlyle once said, "Language is the flesh garment of thought." This fact calls for a discriminating use of words. Words to the medical essayist should be as full of significance as

mathematical symbols to the physicist or mathematician. A synonym has been defined as a word identical and co-extensive in sense and usage with another word of the same language. There are few real synonyms in the language. Therefore, there is a word that is better than any other if we can but find it. Mark Twain once said, "The difference between the correct word and the near correct word is the difference between *lightning* and *lightning bug*." The accomplished writer is as much an artist in the use of words as an artist is skilled in draftsmanship and the use of pigments.

Occasional writers, on medical subjects or other, are guilty of the use of what may be called *jargon*. This is an avoidance of direct speech by the use of foggy expressions. "He was conveyed to his place of residence in an intoxicated condition." Compare with, "He was carried home drunk." "Among the beneficent qualities of sleep—its capacity for withdrawing the human consciousness from the contemplation of immediate circumstances may perhaps be accounted not the least remarkable." Cervantes said the same thus: "How excellent a thing is sleep, it wraps a man round like a cloak."

The use of the split infinitive, while not a literary crime, should be avoided. "The doctor is apt to trust to the law of chance rather than to *thoroughly* go into the history of the case and make a careful examination." "His records showed the incidence to *rapidly* increase."

It is not sufficient that a paper be free from errors in grammar; that is taken for granted. The medical writer should aim at a style that is clear and convincing. There are excellent models in the works of such writers as Osler, Allbutt, Oliver Wendell Holmes, Wier Mitchell, to mention only a few.

Medical papers should be brief. There are very few medical journals which can accommodate the lengthy paper. The demand on space is so great that only a few of the excellent papers written can be accepted.

ALCOHOL AS A DISINFECTANT

Many have been accustomed to look upon alcohol as a safe and efficient sterilizing medium either for use on the skin or in the sterilization of instruments. The New England Medical Journal sounds a note of

warning to those who place their faith in this means of destroying bacteria. Examination of freshly prepared bottles of sterilizing solution taken at random from a ward of one of the large Boston hospitals yielded a growth of spore-bearing bacilli, many of which proved to be Welch bacilli. Alcohol in proper concentration has been proven effective in destroying vegetative forms of bacteria but it has been found to have little or no effect upon the spores of bacteria. The New England Journal mentions experiments by Koch as far back as 1881, demonstrating the failure of alcohol or its dilutions to kill anthrax spores after immersion for one hundred and ten days. The anthrax bacilli spores appear to be particularly resistant to any destructive effects of alcohol.

The note of warning, therefore, is that one should not rely upon alcohol for the sterilization of instruments that are introduced into the body in process of operation. The use of sterile bottles and freshly distilled water in making alcoholic mixtures would be a distinct contribution to safeguarding methods. The fact that more harm has not resulted from the use of non-sterile alcohol is doubtless due to the inherent resistance of the tissues of the human body to infection.

ITEMIZED STATEMENTS

Everyone who has practised medicine for any length of time has met with the demand from patients for itemized statements after the usual monthly bill has been sent showing the amount only of the indebtedness. An itemized bill has the merit of forestalling any complaint on that score. The editor of the Wayne County Medical Bulletin comes forward with a suggestion that is worthy the consideration of all.

"Bills that are not itemized often create resentment in the minds of patients and frequently raise the question as to the validity of the charges made for services. These two factors mitigate against prompt payment of the account in question and are responsible in no small measure for disagreements between patient and doctor.

"The average debtor is interested in having placed before him an itemized account so that he may have the opportunity not only of checking the individual items for which he is being charged, but of adding the sums involved to make sure that no mistake has been made. Since he is the one who is asked to foot the bill, he feels that he has the right to know just what items he is charged with and how much he is paying for each of them. On receiving a bill which denies him this privilege his first reaction is to delay payment until the explanation that he feels is

his due has been made. Almost invariably, a lump sum looks bigger than the same figure arrived at by the addition of a number of smaller charges and is likely to create an undesirable impression of exorbitance.

"The common practice among doctors to send out unitemized statements may be responsible for the feeling that doctors' bills come high, and may be one of the reasons behind the general tardiness in the payment of those bills.

"Those physicians who have changed to the more businesslike method of itemizing their accounts report a decrease in disagreements with patients, and a gratifying increase in collections.

"There is no good reason why the medical profession should not adopt, for the business side of its practice, those tried methods which business in general has found valuable. If so simple a procedure as itemizing our bills promises to eliminate dissatisfaction and speed up payment, then by all means let us all adopt the method and put it into use at once."

LET US MEET AT KAL'MAZOO

We're noo tae hae a meetin' o' th Dōctors o' th State,
An' many men frae many toons, are doon upon th' slate
Tae gi' us information 'boot th' things they like tae do.
They'll tell us a' aboot it, while doon in Kal'mazoo.

There's a lot o' talk o' cancer, th' curse wha's nationwide,
They're workin' nicts an' Sundays, they're high upon th' tide.
These men are mighty earnest in th' work they hae tae do.
They'll tell us a' aboot it, while doon in Kal'mazoo.

Pneumonia an' consumption hae cut an aw'fu' swarth,
An' heart disease is at th' stake, th' ficht is back an' forth,
But Dōctors o' th' country are seein' th' battle through.
They'll tell us a' aboot it, while doon in Kal'mazoo.

They've fought th' mighty fever, diphtheria an' sma' pox,
Th' plague an' childbed fever are noo upon th' rocks.
But yet there's death an' sickness, mair muckle than is due,
Sae gi'es a haund tae help us, whiles doon in Kal'mazoo.

Guid nicht.
—Weelum.

STRICTURE OF UTERINE CERVIX

ARTHUR H. CURTIS, Chicago, believes that stricture of the uterine cervix is of sufficiently frequent occurrence to warrant the interest of every one concerned with pelvic diseases in women. Important symptoms are persistent leukorrhea, dysmenorrhea, the passage of tarry menstrual blood, and pelvic discomfort of varied intensity. Any one or all of these symptoms may be wanting. The pathologic changes include every conceivable variety of strictural obstruction. Dilatation and pocketing of the canal are frequent. Retention of mucoid secretion or tarry blood sometimes produces serious lesions of the upper genital tract and pelvic peritoneum. Stric-

tures may usually be diagnosed by intracervical palpation with Hegar dilators of small caliber. They are often easily demonstrable and readily overcome. At other times the diagnosis is difficult, anesthesia being required not only to reveal whether a stricture is apparent or real but also, when a stricture is present, to determine its nature and the extent of the complicating pathologic changes. The treatment of stricture of the cervix follows well recognized surgical principles. Dilation may suffice; amputation of the cervix is often necessary, and vaginal hysterectomy is occasionally indicated in selected cases.—*Journal A. M. A.*

VITAMIN C ISOLATED

Some months ago it was reported that a Pittsburgh chemist had been successful in isolating Vitamin C. The discovery had the effect of evoking the following protest from the poet of the Manchester Guardian.

O why should they isolate Vitamin C
As if it were something unclean?
I always imagined such buglets to be
The essence of health and hygiene.
So why the pursuit of this promising pup,
This bright dietetic adorning,
In terms so suggestive of rounding it up
And making it stand in the corner?

The word is too *gauche* and ungracious; it ain't
Polite to use phrases that tend
To indicate quite an unpleasant complaint.
Instead of a pal and a friend;
So don't let us "isolate" Vitamin C,
Whose aim is to comfort and nourish—
He ought to be wholly unfettered and free
To multiply vastly and flourish.

O were it not wiser and fairer by far
To round up the viruses bold,
Beginning with him who produces catarrh—
The bug of that foul "common cold"?
By all means detach him and put him away
'Mid wide and deserved execrations—
While virtuous vitamins gambol and play
At large with their friends and relations.

OBITUARY

DR. J. W. HARRISON

Following a collapse while playing golf at Oakland Hills Country Club, Dr. J. W. Harrison, of 926 Balfour Road, Grosse Pointe Park, died August 17th at St. Joseph's Mercy Hospital, Pontiac. Born sixty years ago at Owen Sound, Ontario, Dr. Harrison came to Detroit more than thirty years ago and began his practice after graduating from the Detroit College of Medicine. He was a member of the Detroit Athletic Club, the Lochmoor Golf and Country Club, the Detroit Yacht Club and the Palestine Masonic Society. Professional affiliations included memberships in the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. For many years he served as a physician for the *Detroit News*. The widow, Mrs. Ella M. Harrison, and a son, Dr. J. Wilford Harrison, a dentist, survive.

CONTRACEPTION

Dr. George L. LeFevre, Councillor of the 11th District, advises caution in the matter of the adoption of definite policy on the subject by the medical profession of the State.

During the past year there has been active throughout our state an organization of lay people the purpose of which is to spread information concerning birth control. The movement has now progressed to the point where this organization wishes the approval of the Michigan State Medical Society, and this matter has been discussed by the council of that society. Inasmuch as our attention has been called to this problem, I wish to make my position thereon clear.

The council of our society represents the three thousand or more physicians practicing throughout the state, all with varying ideas, desires, and beliefs. Any statement of policy on the part of the council is far reaching in its effect. Great care must be exercised by that body in placing its stamp of approval or disapproval on any movement. This is an age of fads, and it is most difficult to select from the huge list of fads those ideas which may bring about constructive changes. Only time will mark each as a success or a failure. To preserve the dignity of our organization we must be careful which of these we approve and which we veto. A very serious precedent might be established, from which we could withdraw only with difficulty, by incomplete consideration of any of these problems.

The practice of contraception, as far as our state organization is concerned, is not a religious problem. It is true that many religious organizations have for years disapproved of it. That is their concern and it is not the duty of the council to dictate the religious leanings of its members. This problem is a moral one. There is a definite moral angle which we, as physicians, must consider. The dissemination of information concerning contraception by lay organizations will of necessity lack adequate control. Such information will get to many who should not have it. I am thinking of the young unmarried girls of the danger age, between sixteen and twenty, who, because of fear of the consequences, are now living decent lives. If that fear is removed, one of the greatest forces for control of morals will be destroyed.

There have been many organizations of this character active in England during the

past few years, and now the authorities are becoming alarmed because of the falling birth rate. They have found that the increase in population during the last decade was no more than for the decade preceding, during which the world war was fought. Also the increase in births over deaths has declined from twelve per 1,000 in 1900 to three per 1,000 in 1929. With the population thus rapidly becoming stationary and that of her enemies increasing more rapidly, they naturally have cause for alarm.

The United States has a like problem to face. The birth rate here is also falling slowly, having dropped from 18.9 to 17.8 in the past year. This loss is made up by immigration, which means that our vacant land is being populated, not by our own stock, but by alien material. The effect of this reduction in birth rate is a very serious national problem.

In recent years free clinics of all kinds have sprung up everywhere: pre-natal, pre-school, baby, crippled children, and venereal clinics, all of which tend to reduce the number seeking medical advice from their family physician. Most of them have been instituted by non-medical organizations and have neither the backing nor the coöperation of the medical profession. The council cannot in justice to the membership of the society foster these clinics, and should, for that reason, withhold its support from this, another movement for a free clinic. There may be couples, who, because of disease or other reasons, should or might practice contraception, but the decision as to which cases should and which should not, rests only with the family physician and it is to him they should go, not to a free clinic.

GEORGE L. LEFEVRE, M.D., F.A.C.S.

ABERRANT THYROID

Richard B. Cattell, Boston, reviews thirteen cases of lateral aberrant thyroid. All showed a similar structure of papillary cystadenoma. In considering this group of cervical tumors, the author points out the low grade of malignancy as compared with other epithelial tumors involving the cervical glands. These tumors frequently go unrecognized and may be reported as metastatic carcinoma of unknown origin in the cervical glands. It is believed that neck tumors, outside of the thyroid gland showing papillary cystadenoma, are of lateral aberrant thyroid origin and are the result of arrested development. Satisfactory results were obtained by radical removal followed by post-operative irradiation. It is important to recognize them, since a good prognosis can be given.—*Journal A. M. A.*

ONE HUNDRED YEARS OF MEDICAL PRACTICE IN OAKLAND COUNTY VILLAGE

The village of Milford has celebrated its one hundredth birthday. The Journal hastens to extend its congratulations. Dr. C. A. Neafie, Director of Public Health of Pontiac, has taken occasion to compile the medical history of Milford during the past century. The following is Dr. Neafie's account of this section of Oakland County. A year ago, it will be remembered, the Oakland County Medical Society celebrated its 100th anniversary. Dr. Neafie is Councilor for the Fifteenth District of the Michigan State Medical Society.

On the occasion of the Milford Centennial it is but fitting that we pay our humble tribute to that splendid group of pioneer medical men who not only took care of the sick, but also participated in the educational, commercial and civic development of the village during its early years.

The practice of medicine in pioneer days was carried on under great difficulties and the doctor's life was one of many hardships and privations. His patients were widely scattered about the country, necessitating long rides over the Indian trails, along the course of the streams, or over newly laid out roads which were always rough and, in stormy weather, often impassable. He made his way about the country on horseback, his saddlebags containing such instruments and drugs as he would have occasion to use. He would often be away from home for days at a time, particularly during the "sickly" season between June and October, when it was the rule for almost everyone to suffer from the "ague" or what we now know as malaria.

The pioneer physician owed much to his faithful, well-trained horse, who, day and night, carried him on his errands of mercy, often going without food while serving as food for the myriads of flies and mosquitoes which were so prevalent in pioneer days.

It is certain that the early practitioners of Milford were men capable of carrying on their work, in the care and relief of the sick, with every available means and influence. Many of these physicians were graduates of eastern medical colleges, some of European institutions, while others who did not have the advantage of a collegiate education had served a long and active apprenticeship under a preceptor. All had to earn the right to practice by passing a rigid examination given by the Board of Censors of the Territorial or State Medical Society or that by a similar board of the Oakland County Medical Society.

They were the educated men of the village and therefore the influential citizens.

As family physician they sustained with their patients the relation of counsellor and friend.

It has been said that the pioneer doctor was generally present at all the important family events: "He was present at every birth, he sat with the minister by every deathbed, and his signature was affixed as a witness to every will."

The first physician to locate at Milford was Dr. Henry King Foote (1803-1863), a native of East Haddam, Conn. He studied medicine in Vermont and at Albany, N. Y. He began the practice of medicine in Conesus, N. Y., where he remained until 1834, when he came to the territory of Michigan. He was licensed to practice in Michigan territory by the Oakland County Medical Society, of which organization he was an active member. He first settled on a farm in Commerce township near the present village of Wixom. In the spring of 1837 he located in the prospective village of Milford. For many years he was a leader in the development of the community, and served several terms in the legis-

lature. In 1862 he enlisted in the Union army and was commissioned a lieutenant in the Fifth Michigan Cavalry, later being commissioned surgeon of this organization. He died from pneumonia at Poolesville, Maryland, February 8, 1863.

Dr. Daniel Arms (1787-1840) was born in Brattleboro, Vermont. In 1834 with his family, he came to Michigan from Penfield, Monroe county, New York. He first located at Northville, where Mrs. Arms' brother, Dr. David Gregory, had settled in 1833, and was practicing his profession. His sons, Ansley S. Arms and William A. Arms, located at Milford in 1836, the doctor and his family following sometime later. He lived but a short time in the pioneer village, his death occurring in 1840.

Dr. Daniel A. B. C. Fox (1798-1840), who was often spoken of as "Alphabet" Fox, was born in New Hampshire. "Being the seventh son and no intervening daughter, according to the usually accepted maxim, he must be a doctor, and accordingly was educated for that profession." After practicing for some years in the east, he came to Michigan, arriving in Detroit July 4, 1838. The doctor decided to locate in the promising village of Milford and here the family settled. He was licensed to practice by the Oakland County Medical Society and held membership in that society. The toils, privations and constant cares attendant upon his profession proved too much for the doctor and he succumbed to illness. He died in 1840, leaving a widow and eight children, among them being Truman B. Fox, who established the Rochester "Era" and whose son, W. A. Fox, is the present publisher.

Dr. Zebina Montague Mowry (1804-1874), was a native of Cheshire, Mass., the son of Elisha and Barbara Barker Mowry. He graduated from the Berkshire Medical College, Pittsfield, Mass., in 1827. He began the practice of medicine at Madison, N. Y. In 1838 he came to Michigan, locating on a farm in the vicinity of Ann Arbor. In 1841 he removed to Milford and entered into partnership with Dr. Henry K. Foote, an association that continued up to the date of the latter's enlistment in the army in 1862. Dr. Mowry served his township on the Board of Supervisors in 1845 and 1846, and was chairman during the latter year. In 1847 and 1849 he represented his district in the State Legislature, and in 1850 was a member of the Constitutional Convention. He was a member of the Oakland County Medical Society and of the Union Medical Society of Wayne, Washtenaw and Oakland Counties. In May, 1866, he became associated in practice with Dr. Robert Johnston, continuing the arrangement until June, 1873, when failing health necessitated his withdrawal. His sudden death occurred in August, 1874. He showed distinguished ability as a physician, was highly esteemed as a citizen, and during his thirty-three years of residence in Milford rendered exception service to the community.

Another early physician in this locality was Dr. Barnabas Holmes (1780-1844), who came from St. Lawrence County, New York. He was licensed to practice medicine by the Medical Society of the Territory of Michigan July 26, 1830. But little information is available concerning him. He is buried in the Milford cemetery.

Dr. David S. Martin was the pioneer homeopathic physician in Milford, locating in this village in 1845. In 1875 he exchanged his property in the village for a farm in White Lake, but within a short time removed to California.

Dr. Alexander Bryce was practicing in Milford about 1849.

Dr. Robert Browne, a native of Stranorlar, Ireland, graduated in medicine from the University of Glasgow, Scotland. He located at Milford in 1849 and practiced for several years. Later he removed

to Grand Ledge, where he died sometime in the seventies. He was a brother of Dr. Joseph Browne.

Dr. Joseph Browne (1803-1877) was born at Stranorlar, Ireland, the son of Samuel Browne. He was educated in the University of Glasgow, Scotland, and for over twenty years served as a surgeon in the British navy. Later he served in the United States navy in a similar capacity. In July, 1850, he established his home in Milford, where he passed the remainder of his long and useful life, a distinguished member of his profession and a man of high intellectual attainments. He was a brother of Miss Frances Browne, the famous blind poet of England.

Dr. Robert Johnston (1838-1904) was born in Washington county, Pennsylvania. In 1842 the family moved to Ralls county, Missouri. He attended the local schools and when eighteen years of age began teaching school and at the same reading medicine at Madisonville, Missouri. He later entered the University of Iowa, but when the war broke out he enlisted in the Fifth Missouri Infantry. After six months he was honorably discharged and entered the Ohio Medical College at Cincinnati, where he graduated on July 3, 1862. He at once reentered the Union service and was soon appointed assistant surgeon of the 100th Ohio Volunteer Infantry and early in September began field service. He was in many of the battles in Kentucky, Tennessee and Georgia. He was captured at the battle of Limestone Bridge and sent to Libby prison, where he was confined for two months. Upon his release he rejoined the 100th Ohio, serving until mustered out at Cleveland at the close of the war, July 31, 1865. He continued the study of medicine and surgery at the Bellevue Hospital Medical College, New York, where he graduated in 1866. The same year he located at Milford, entering into partnership with Dr. Zebina M. Mowry and continued in practice until his sudden death in May, 1904. For twenty-seven years he served as director of the Milford School Board. He was president of the Union Medical Society of Wayne, Washtenaw and Oakland Counties 1876-77, a member of the American Medical Society, Michigan State Medical Society, and the Oakland County Medical Society.

Dr. William Fitch Hovey graduated from the medical department of the University of Michigan in 1853. Within a short time he located at Orionville. He served in the army during the Civil war, and on its conclusion practiced at Fenton. In 1868 he located at Milford. He was one of the organizers of the Union Medical Society in 1871. In 1875 he removed to Bay City, where he died in 1907.

Dr. Dallas Starr, who practiced at New Hudson as early as 1856, was practicing in Milford in 1873. In 1876 he sold his home and removed to Birmingham.

Dr. Calvin C. Kingsbury, who practiced at Novi for many years, opened a drug store in South Milford in January, 1874. He practiced but a short time in Milford, removing to Bay City in 1875. In 1886 he was located at Brighton.

Dr. Alexander Dunlap Hagadorn (1843-1918) graduated from the University of Michigan in 1871 and began practice at Highland. In 1874 he located at Milford. He was one of the organizers of the Union Medical Society in 1871, frequently held office in the society and in 1877-78 served as its president. In 1881 he removed to Lansing, where he practiced for many years. He was at one time President of the Ingham County Medical Society.

Dr. Cyrus Griswold Davis (1843-1899) graduated from the University of Michigan in 1871 and began practice in Tuscola County. In December, 1875, he removed to Milford, where he practiced for many

years, and was also in the drug business. He died in Milford November 20, 1899.

Dr. R. F. McTavish, a homeopathic practitioner, located at Milford in 1876.

Dr. G. B. Gregory, another follower of the teachings of Hahnemann, located here in 1877.

Dr. John D. Campbell graduated from the University of Michigan in 1878 and in November, 1879, located at Milford. He later practiced at Pioche, Nevada.

Dr. Dallas Warren (1850-1927) was born in Northfield township, Washtenaw county, the son of Hiram G. Warren. He graduated from the University of Michigan in 1879 and began practice at Highland. In 1881 he removed to Milford. In 1909 he moved to Detroit, where his death occurred.

Dr. Thomas Jefferson Jackson (1847-1930) graduated from the homeopathic department of the University of Michigan in 1880 and located at Milford the following year, practicing until within a short time of his death, which occurred in Detroit, April 23, 1930.

Dr. John C. Black (1863-1920) graduated from the Detroit College of Medicine in 1887 and located at Clyde. Within a short time he removed to Milford. He was a member of the Michigan State Medical Society and a charter member of the Oakland County Medical Society. His sudden death in March, 1920, was a distinct loss to the community.

Dr. William Grant Bird graduated from Detroit College of Medicine and Surgery in 1895 and located at Milford. He is now practicing in Flint.

Dr. Robert W. Cooper, a graduate of Michigan College of Medicine, Detroit, class of 1892, located at Highland in 1903. He removed to Milford within a short time and practiced there for some years.

The dean of present day Milford practitioners is Dr. Edward Augustus Lodge. Dr. Lodge was born in New York City on October 31, 1856, a son of Dr. Edwin Albert Lodge, who moved with his family to Detroit in 1859. Dr. Lodge graduated from the homeopathic department of the University of Michigan in 1879 and located at Milford in 1881. He is the second oldest practitioner in Oakland County, the oldest being Dr. Charles P. Felshaw of Holly, who began practice at Ortonville in 1867.

GENERAL NEWS AND ANNOUNCEMENTS

The Council of the Wayne County Medical Society, the Detroit Board of Commerce and the Mayor of Detroit, have joined in an invitation to the Michigan State Medical Society to hold the 113th annual meeting in Detroit.

Mrs. Charlotte Luce, mother of Dr. Henry A. Luce of Detroit, died at her home at Linden, Michigan, on August 13 at the advanced age of eighty-seven years. Dr. Luce has the sympathy of the medical profession in this sad bereavement.

Detroit has been absolutely free from smallpox for over a year, which is the best record the city has had within recent years. This showing is attributed to the fact that a great many people appear for vaccination even during the time when no smallpox epidemic is threatening.

"Dr. Frank A. Kelly was re-elected for the seventh consecutive time as Treasurer of the Wayne County

Medical Society by the Board of Trustees at its meeting of July 22, 1932. Dr. Kelly has been Treasurer under Presidents J. H. Dempster, G. Van Amber Brown, E. G. Martin, A. S. Brunk, J. M. Robb, H. W. Plaggemeyer and H. Wellington Yates."—*The Bulletin of the Wayne County Medical Society.*

The third annual golfing tournament under the auspices of the Wayne County Medical Society will be held on Wednesday, September 7, at the Thorncliffe Golf Club. A dinner will be served in the evening, following which will be an entertainment and the presentation of prizes to the successful players.

Dr. Vernon L. Hart will be associated with the Dayton Clinic, Dayton, Ohio, after October 1st and will be in charge of the Orthopedic Service at the clinic. At the present time he is Assistant Professor and Surgeon in charge of the Bone and Joint Division of the Department of Surgery at the University Hospital, Ann Arbor.

Dr. Albert E. Bulson, editor of the Indiana State Medical Journal, died on July 17, 1932. Dr. Bulson had been editor of the Indiana Medical Journal for nearly a quarter of a century. He was a native of Michigan where he graduated from Michigan State College in 1888 and from Rush Medical College in 1891. His specialty was ophthalmology and otolaryngology. The passing of Dr. Bulson removes one of the most versatile editors of state medical journals in the country.

The new Receiving Hospital costing the state \$300,000 at the Michigan Farm Colony at Wahjamega near Caro was opened on August 11 by Governor Brucker. Among those present were members of the State Hospital Commission. Mr. R. G. Ferguson, Chairman of the Commission, presided. The Michigan Farm Colony for epileptics was opened in 1914 with fourteen; at the present time the number of patients is reported to be 932, with 500 on the waiting list.

AN INVITATION FROM THE AMERICAN ROENTGEN RAY SOCIETY

The Thirty-third Annual Meeting of the American Roentgen Ray Society is to be held in Detroit September 27 to 30 at the Book Cadillac Hotel. Members of the Michigan State Medical Society are cordially invited. The first session, beginning at 9 A. M. on Tuesday, September 27, will be given over to the discussion of diseases of the joints, and the various aspects will be presented by Dr. Ralph K. Gormley, Drs. D. B. Phemister and C. Howard Hatcher, Dr. Walter Bauer, Dr. Max Harbin and Dr. Leo C. Rigler.

Having in mind the demands on the physician associated with the increased medicolegal and industrial practice, the session on Tuesday afternoon, September 27, will be given over to papers dealing with various phases of this subject. The material will treat "The Relation of Trauma to Arthritis," "The Relation of Trauma to Cardiac and Pulmonary Disease" and to malignancy. The discussion will also include traumatic neuroses, a paper by Dr. J. Albert Key on "Bone Atrophy" and a paper by Dr. Henry H. Kessler, who wrote the textbook entitled "Accidental Injuries" on "Anatomic Basis for Disturbed Function." There will also be a presentation by Dr. Samuel H. Rhoads, Chairman of

the Department of Labor and Industry of the State of Michigan, on "The Value of Expert Testimony."

Recognizing the importance of roentgenology in the detection and treatment of tuberculosis, a full session will be given on Wednesday morning, September 28, to tuberculosis. This symposium could well be entitled "The Ideal Program for the Detecting and Control of Tuberculosis." The various phases have been assigned to members of the Division of Tuberculosis of the Detroit Department of Health. In addition, Dr. Max Pinner will read a paper on "Roentgenological Manifestations of Allergic Processes in Pulmonary Tuberculosis."

Gynecology has been remarkably influenced by roentgenology, in both the diagnostic and therapeutic aspects, and obstetricians also find this study of value in certain cases, and the session of Wednesday afternoon, September 29, will be taken up by a discussion of the use of "Roentgenology in Gynecology and Obstetrics." Dr. Healy of Memorial Hospital of New York is to present a paper on the subject of "The Treatment of Malignancy of the Female Pelvis." A paper of equal importance will be given by Dr. George Pfahler on the subject of "Irradiation of Benign Conditions of the Uterus."

The session of Thursday morning, September 29, will deal with miscellaneous subjects, including a paper by Dr. B. R. Kirklin on "Hypertrophy of the Pyloric Muscle and Duodenitis; Their Association and Roentgenological Manifestations," a paper by Dr. Harry M. Weber on "The Roentgen Demonstration of Non-Malignant Lesions of the Colon" and a paper by Dr. Aubrey Hampton of the Massachusetts General Hospital on "Chronic Ulcerations of the Stomach." A discussion of pulmonary atelectasis will be given by Dr. Willis F. Manges of Philadelphia.

Of unusual interest to physicians engaged in the practice of radiation therapy will be the program of Thursday afternoon. The Memorial Hospital group of New York will present a series of papers dealing with the relative effects produced by 200 kv X-rays, 700 kv X-rays and gamma rays.

Appreciating the importance, especially to roentgenologists, of the work done by Dr. Max Ballin and Dr. P. F. Morse on disease and dysfunction of the parathyroids, the entire day of Friday, September 30, will be given over to the consideration of this subject under the heading "Malacic Diseases of Bones." The question will be considered clinically, pathologically and from the etiological aspect. Roentgenologically, the subject will be treated under the following headings: Rickets (fetal, infantile, late), Osteomalacia, Primary Parathyroidism (osteitis fibrosa cystica, Paget's disease, leontiasis osseum, giant cell sarcoma, ankylosing polyarthritis of Oppel, osteopoikilosis, marble disease, Kashin-Beck disease, renal rickets) Osteogenesis Imperfecta, Decalcification in Other Endocrine Disturbances (Graves' disease and thyroid deficiency, diabetes, pituitary origin-basophile adenoma, adrenal), Christian's syndrome, and Cooley's syndrome.

The medical profession is also invited to the evening sessions. That of Tuesday evening, September 27, will be a discussion of the use of the X-ray in industry and will include a paper by Dr. George L. Clark of the University of Illinois on "X-ray in Industry and other Non-Medical Fields." On Wednesday evening, September 28, the annual Caldwell Lecture will be given by Dr. A. W. Crane of Kalamazoo. Dr. Crane will discuss "The Clinical Aspects of Roentgenology."

In addition to the formal papers, special attention is being given to the Scientific Exhibit and all those in attendance at the meeting are urged to study this carefully, for much of interest is to be presented.

SOCIETY ACTIVITY

INVITED GUESTS

The following invited guests will address the sectional and general meetings during our annual session. Each one is an outstanding individual in his special field. They will make valuable and helpful contributions to our program. Those who hear them will receive profitable inspiration. Determine to be present.

Olin West, Secretary and General Manager, American Medical Association.
 Morris Fishbein, Editor, Journal A. M. A.
 Joel E. Goldthwait, Boston.
 George F. Suker, Chicago.
 M. F. Arbuckle, St. Louis.
 W. I. Lillie, Rochester, Minn.
 H. J. Parkhurst, Toledo.
 S. W. Harrington, Rochester, Minn.
 Samuel Levine, Boston.
 Joseph Miller, Chicago.
 Warren Vaughan, Richmond, Va.
 Fred Falls, Chicago.
 E. J. Matsner, New York.

WOMAN'S AUXILIARY

The Michigan State Medical Society Woman's Auxiliary is all prepared for two days of sessions and social functions during our Kalamazoo meeting. Their program will be found in this issue.

The state auxiliary is accomplishing much that is worth while and is an influential helpmate in meeting medical and health problems. We need their help and they need our assistance.

To encourage them bring your wife to Kalamazoo and while you are attending sessions have her meet and mingle with the Auxiliary at their sessions and functions.

WHY—AN ANNUAL MEETING

This issue contains the completed program for our 112th annual meeting in Kalamazoo on September 13, 14 and 15.

That program contains many reasons as to why you should be in attendance. It imparts how you may obtain personal profit. Observe the list of speakers and their subjects. Then ask yourself if you can afford not to obtain the instruction and aid that will come to you by hearing these discussions. This session will be a real post-graduate two-day course of value to every doctor.

The scientific and commercial exhibits

will also contribute worth-while information and instruction.

The "Talkie Movies," obtained through the courtesy of the Petrolagar Laboratories, will be worth seeing and hearing.

You will meet your fellow members and former classmates. The social hours will lift the burden of care and infuse a brighter spirit in you.

Sure, we are all pressed for funds—still the small expense entailed to attend will yield you dividends that will go far in reimbursing that bank account. You will have a zeal to work better and harder when you return home and that's what we all need today.

Education, instruction, inspiration, personal enhancement and a happier state of mind are engendered—that is why we have an annual meeting and urge you to attend.

REMINDERS

1. Write for your hotel reservations.
2. Register on arrival at the Registration Booth, basement of the Presbyterian Church House.
3. Plan to see the Scientific and Commercial exhibits. They are well worth your time and merit your patronage.
4. Your wife will enjoy attending the Auxiliary meetings.
5. Delegates should secure their credentials from their county secretary and present them to the Credentials Committee at the first meeting of the House of Delegates at 10:00 a. m., September 13.
6. If a delegate cannot attend arrange for the attendance of an alternate. Your county is entitled to representation.
7. Consult the official program in this issue—it contains full information.
8. The Kalamazoo profession bids you welcome.

A BIT OF HISTORY

Previous to 1887 our state society met in annual meeting for a period of three days. The sessions were general and all papers, discussions and business were presented before those present seated in a general assembly.

In 1885 it had been recommended that a committee be appointed to present a new plan of organization. In 1886 three sec-

tions were recommended but no action was taken.

In 1887, the society convened in Lansing in May. At the first session Dr. Donald Maclean moved: "To establish three sections in order to facilitate professional and scientific work, viz: A section on medicine, section on Surgery, a section on Midwifery and Gynecology. At each annual session a chairman shall be chosen, who shall serve for one year. A secretary shall be chosen for two years. These sections shall hold their sessions in the afternoon and the society shall meet in general session in the forenoon of each day."

"The motion was carried and the society proceeded to divide into sections and adjourned to their respective rooms."

The section on medicine elected as its first officers: Dr. A. W. Alvoord, of Battle Creek, chairman. Dr. H. B. Hemenway, Kalamazoo, was elected secretary.

Dr. Donald Maclean of Detroit and Dr. F. W. Mann of Detroit were elected chairman and secretary of the section on Surgery.

The section on Midwifery and Gynecology elected Dr. Geo. E. Ranney of Lansing, chairman, and Dr. N. W. Webber of Detroit as secretary.

For forty-five years sectional meetings have characterized our annual programs.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

The Executive Committee of the Council met in Ann Arbor on Wednesday, July 20, 1932.

Present: B. R. Corbus, Chairman; Henry Cook, J. D. Bruce, C. E. Boys, G. L. LeFevre, C. F. Moll, President; J. M. Robb, President-Elect; J. H. Dempster, W. H. Marshall, F. C. Warnshuis, Secretary.

1. The Secretary reported upon the arrangements that were being perfected for the holding of our Annual Meeting in Kalamazoo on September 13-15. After discussion of the details, the program, the local arrangements and the exhibits, the Secretary was directed on motion of Bruce-Cook to proceed and arrange for holding the scientific and commercial exhibits as in former years.

2. Upon motion of Cook-Le Fevre, in order to circumvent any discussion or criticism in regard to a controversial question, the Secretary was directed not to lease a booth to any representative of organizations active in furthering the programs related to birth control.

3. Upon motion of Bruce-Boys, the Secretary was directed to convey to the officers of the section on Gynecology and Obstetrics that it was the sense of the Executive Committee that the address of Dr. Masters should be delivered before their section and not at the combined section meeting.

4. Upon motion of Le Fevre-Bruce, the Secretary was directed to send out notices that the first meeting of the Council would be held in Kalamazoo

at eight o'clock on the evening of September 12, 1932.

5. The Secretary presented a communication from the Council of the Wayne County Medical Society requesting a rebate on the dues of three members who had been expelled from the society. After full discussion a motion by Cook-Bruce directed the Secretary to send a voucher rebating half of the year's dues to these expelled members.

6. The Secretary presented a detailed, itemized statement as to the expenses and finances of the Society. This was thoroughly reviewed. On motion of Bruce-Le Fevre, the Secretary was directed to advise all standing committees to limit the committee expenses in so far as possible and not to incur the expense of committee meetings without first making application and securing authorization for such expenditure.

7. Upon motion of Bruce-Cook, \$400.00 was appropriated for clerical work required by the Committee on Survey of Medical Service and Health Agencies.

8. Dr. Marshall and Dr. N. Sinai presented a detailed report of the work that was being done and the work that had been accomplished by the Committee on Survey of Medical Service and Health Agencies. After a free and full discussion on motion of Bruce-Le Fevre, the report was accepted and the Executive Committee expressed approval of the plan of procedure under which the committee was working.

9. On motion of Cook-Bruce, President Moll was designated to represent the Society at the Upper Peninsula Medical Society meeting on August 11 and 12.

The committee adjourned.

F. C. WARNSHUIS, Secretary.

The Upper Peninsula Medical Society held its annual meeting on August 6 and 7 at Sault Ste. Marie, Michigan. The meeting was well attended. Dr. E. H. Webster of Sault Ste. Marie was chosen president of the Upper Peninsula Medical Society for the ensuing year. The next meeting will be held at Escanaba, Michigan. A number of excellent papers were presented. The banquet in the evening was addressed by Ex-governor Chase Osborne. Drs. Carl F. Moll, Flint, Michigan, President of the Michigan State Medical Society, J. M. Robb, president-elect of the Michigan State Medical Society and Dr. Louis J. Hirschman were also speakers at the banquet.

(Continued from Page 584)

Typhoid paratyphoid vaccine, 1 c.c. vials
Typhoid paratyphoid vaccine, 10 c.c. vials

*Poliomyelitis convalescent serum, 20 c.c. vials
*Poliomyelitis convalescent serum, 30 c.c. vials

Sodium citrate, 4% solution, 2 c.c. vials

Tuberculin "OT," 1 c.c. vials
Von Pirquet, 2 test, 5 test and 50 test packages

Normal horse serum (any amount)
Rabies vaccine, Cumming, 7 doses per package
Kahn antigen, 10 c.c. ampoules
Diagnostic sera, 1 c.c. vials. Specify kind.
Bacteriophage, 5 c.c. vials {Staphylococcus, Strepto-
Bacteriophage, 20 c.c. vials {coccus, B. coli,
B. typhosus

Effective August 1, 1932.

*Supplied by the Michigan Commission on Infantile Paralysis and consultants, during the "poliomyelitis season" (July, August, September, October)

THE DOCTORS' LIBRARY

MEDICAL CLINICS OF NORTH AMERICA. (Issued serially, one number every other month.) Volume 16, Number 1 (Philadelphia Number, July, 1932). Octavo of 290 pages with 75 illustrations. Per Clinic year, July, 1932, to May, 1933. Paper, \$12.00; Cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1932.

NEW AND NON-OFFICIAL REMEDIES, 1932, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1932. Cloth. Price, postpaid, \$1.50. Pp. 492. Ivi. Chicago: American Medical Association.

The recognition of a preparation for inclusion in this book singles it out from the host of new products of the pharmaceutical manufacturers as being a worth-while addition to the existing armamentarium of the practicing physician. To be thus distinguished it must be shown, under the impartial scrutiny of the carefully chosen group which is the Council on Pharmacy and Chemistry, that it has acceptable evidence of therapeutic usefulness and that it is marketed in accordance with the honesty and straightforwardness envisaged by the excellent Rules which have been the outgrowth of the Council's quarter century experience in appraising the merits of new drugs.

In accordance with its custom of keeping the annual editions of New and Non-official Remedies in the forefront of current medical thought, the Council offers in this volume the newly revised articles: Barbitol and Barbitol Compounds; Fibrin Ferments and Thromboplastic Substances; Liver and Stomach Preparations; Mercury and Mercury Compounds; and Ovary. Perhaps the most noteworthy new preparations admitted are: nupercaine-Ciba, a local anesthetic; pentobarbital sodium, a barbituric acid derivative; and iopax, a new preparation for roentgenologic use. All of the ovary preparations formerly described are omitted and none of the new standardized preparations are described, although the names Theelin and Theelol are recognized in the revised general article. Another change of importance is the classification of articles formerly listed as "Exempted" under the heading "Accepted but Not Described." There is the usual excellent index and the augmented Index to Proprieties Not Included in N. N. R.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1931. Cloth. Price, \$1.00. Pp. 100. Chicago: American Medical Association.

This volume contains the collected reports of the action of the Council on Pharmacy and Chemistry on all products which have been found unacceptable or which have been omitted from New and Non-official Remedies during the past year. It contains also the special reports authorized by the Council during the year and preliminary reports on articles which show promise but which are not yet ready for admission to New and Non-official Remedies nor suitable for general use by the medical profession. Among the reports on products found unacceptable are those on Thymophysin, a preparation of posterior pituitary and thymus, advocated as a safe and reliable means of accelerating delivery and marketed under false claims as to its essential action, as to its strength, and as to its safety for mother and child; on Bismuthoidal, claimed to be colloidal bismuth, and marketed with unwarranted claims of value in the treatment of syphilis intravenously; on Frenly Enema Cream, a complex, unscientific mixture, marketed under a therapeutically suggestive name with unwarranted claims of therapeutic value in a

host of conditions; on Hayner's Normaline, an unoriginal preparation of formaldehyde and zinc chloride marketed under a non-informing name without a quantitative statement of composition on the label or in the advertising and with unwarranted and misleading claims; on Pernocton, a barbituric acid product marketed under a therapeutically suggestive name and with unacceptable recommendations for intravenous use; on Solution Normet, an unscientific mixture of citrates, marketed with unwarranted claims; on Alqua Water, Calso Water, and Alka Water, irrational, proprietary "alkalizing" mixtures marketed with unwarranted and misleading claims. The preliminary reports on Nucleotide K 96, a preparation of pentose nucleotides which has shown promise in the treatment of leukopenia, and on Carbarsone, p-carbamino-phenyl arsonic acid, proposed for use in amebiasis but needing further confirmatory evidence of value, are both timely and interesting. Perhaps the most noteworthy are the special reports, The Intravenous Use of Barbitol Compounds and The Average Optimum Dosage of Cod Liver Oil. The former gives the Council's considered verdict on the dangers and limitations of the use of barbitals intravenously and the latter gives the result arrived at from a questionnaire sent to leading pediatricians.

RECENT ADVANCES IN PATHOLOGY by Geoffrey Hadfield, M.D., F.R.C.P., London, Professor of Pathology in the University of London, and Lawrence P. Garrod, M.A., M.B., M.R.C.P., London, Bacteriologist and lecturer in Bacteriology, Late Demonstrator of Pathology, St. Bartholomew's Hospital; 67 illustrations. Price \$3.50; Philadelphia. P. Blakiston's Son and Company, Inc.

This book of nearly four hundred pages, as the title indicates, is concerned with the latest advances in knowledge of specific diseases rather than the more abstract problems that underlie them. The authors in their selection of subjects have been guided by the importance from a clinical point of view, so that we have considerable space devoted to the pathology of respiration diseases, to Bright's disease, to the cardio-vascular system, to diseases of the central nervous system and to the ductless glands. This series of "Recent Advances" (other numbers we have had occasion to review) form a valuable supplementary literature to the older and more complete works on the subjects treated.

CLASSIC DESCRIPTIONS OF DISEASE. By Ralph H. Major, M.D., Professor of Medicine, University of Kansas School of Medicine. Illustrations. The book is beautifully printed. Price \$4.50.

This work presents in English three hundred seventy-six selections from the original, epoch-making accounts of one hundred seventy-nine authorities, whose contributions and discoveries have furnished the foundation of our knowledge of clinical medicine.

These basic materials and their one hundred thirty illustrations of unusual portraits, facsimiles of title and text pages, reproductions of apparatus and drawings, represent a wide investigation of the medical literature. Grouped by subject divisions, within each division the work is arranged chronologically. Exact references are given to the original sources. Brief summaries, and terse historical and biographical paragraphs precede each division and most author's accounts.

This new and fertile collection of selections makes available basic and fundamental works with which every physician desires to be familiar, as a most casual inspection of the contents will indicate.

It has been a long time since we have found such an interesting, entertaining and instructive text. Every student of medicine should be compelled to read it. Every practitioner should be urged to embrace the opportunity of profiting by similar study. We are indebted to the author for his contribution.